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Resident Physician

1960

FEBRUARY

Vol. 6, No. 2

JOURNAL FOR THE HOSPITAL STAFF OFFICER

610.5

R434

an appraisal:

ADVANCED EDUCATION

for General and Specialty Practice

THE UNIVERSITY
OF MICHIGAN

MAR 3 1960

MEDICAL
LIBRARY

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What I Learned About

NIGHT CALLS

page 62

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February 1960, Vol. 6, No. 2

Resident Physician

Articles

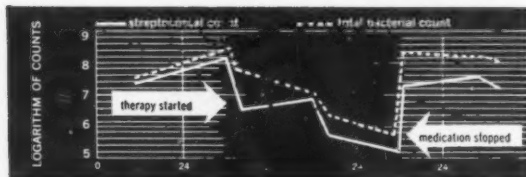
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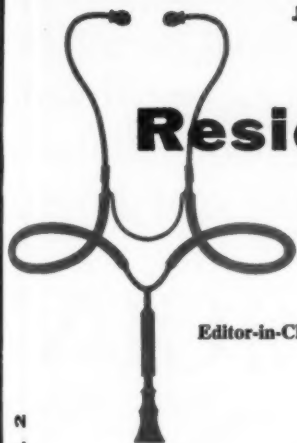


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Symbol of service in medicine

1. Clein, N. W.: *Pediat. Clin. North America*, Nov., 1954, pp. 949-962.

Journal for the Hospital Staff Officer



Resident Physician

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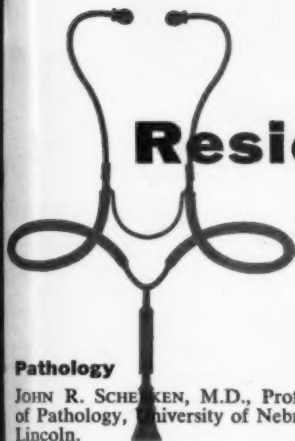
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Antib
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The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk(*).

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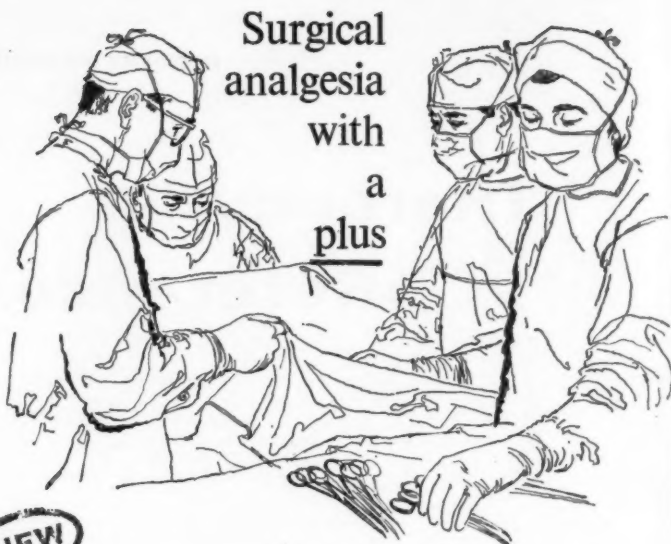
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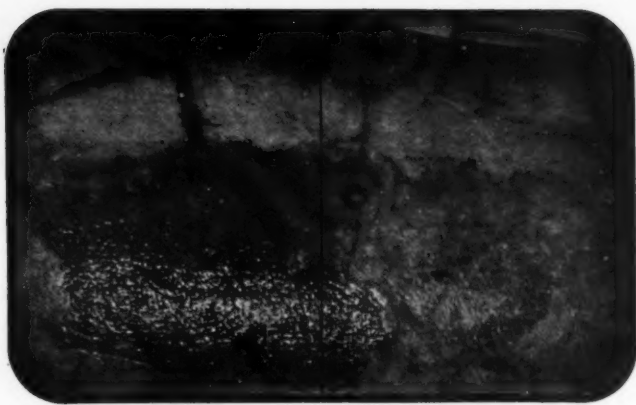
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Skin graft donor site after 2 weeks' treatment with...
 petrolatum gauze—still largely granulation tissue | FURACIN gauze—completely epithelialized

OBJECTIVE EVIDENCE OF SUPERIOR WOUND HEALING

was obtained in a quantitative study of 50 donor sites, each dressed half with FURACIN gauze, half with petrolatum gauze. Use of antibacterial FURACIN Soluble Dressing, with its water-soluble base, resulted in more rapid and complete epithelialization. No tissue maceration occurred in FURACIN-treated areas. There was no sensitization.

Jeffords, J. V., and Hagerty, R. F.: *Ann. Surg.* 145:169, 1957

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 the broad-range bactericide that is *gentle to tissues*

spread FURACIN Soluble Dressing: FURACIN 0.2% in water-soluble ointment-like base of polyethylene glycols.

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 neither antibiotics nor sulfonamides*



Viewbox Diagnosis



Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

Thirty-year-old female.

Chief complaint—right lower quadrant discomfort.

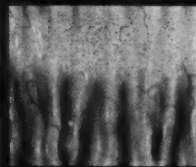
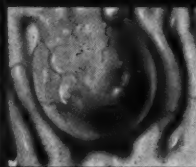
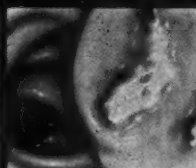
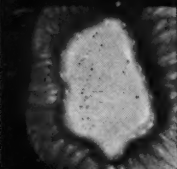
Which is your diagnosis?

- | | |
|-------------------------------|-----------------|
| 1. Stone in right ureter | 3. Dermoid cyst |
| 2. Calcified mesenteric nodes | 4. Lithopedion |

(Answer on page 173)



in
inflammatory
anorectal
disorders...



SYMPTOMATIC RELIEF IN 96% OF PATIENTS TREATED* WYANOIDS® HC

Rectal Suppositories with Hydrocortisone, Wyeth

- *pruritus ani*
- *proctitis*
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*Schneider, H.C.: *In Press, J. Intern. Coll. Surgeons*

Supplied: Suppositories, boxes of 12. Each suppository contains 10 mg. hydrocortisone acetate, 15 mg. extract belladonna (0.19 mg. equiv. total alkaloids), 3 mg. ephedrine sulfate, zinc oxide, boric acid, bismuth oxyiodide, bismuth subcarbonate, and balsam peru in an oleaginous base.

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14. Natio
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16. Elect
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18. Land
19. Moist
20. Tooth
22. Fores
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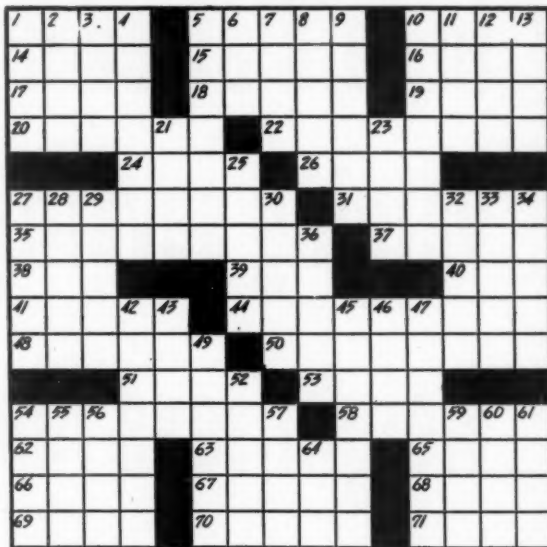
1. German title of nobility
5. Billiard shot
10. Ceylonese monkey
14. National Foundation needs _____ money
15. Synthetic fiber
16. Electric od (Abbr.)
17. Roaster
18. Landed proprietor
19. Moist
20. Tooth (Comb. form)
22. Foreskin (Pl.)
24. Attractive by reason of daintiness
26. Aromatic hydrocarbon radical
27. What polio vaccine produces
31. Pertaining to pituitary site
35. Founder of the NFIP
37. _____tia, joy (Lat.)
38. Liver fluke disease
39. Annamese tribes
40. _____oplegia, one-extremity paralysis
41. Oklahoman Indian tribe
44. Showed that Eastern cotton rat can be given polio
48. Thomas H. _____ sharer of 1954 Nobel Prize for polio research
50. Cells directly attacked by polio
51. River (Tagalog)
53. Draw out and twist wool
54. _____ to polio, not uncommon in summertime crowds
58. Pyrexia
62. Medicinal drinks made from herbs
63. _____ Globulin
65. _____nthe, Gilbert and Sullivan operetta
66. Acouad
67. _____ropia, normal refraction of the eye
68. _____para, Childless woman
69. _____erol, Muscle relaxant
70. Separate a tissue for microscopic examination
71. Search

DOWN

1. _____ spasm, Rotatory spasm of the head
2. Crucifix
3. _____nomic nervous system
4. Man in charge of evaluating polio vac-

Resident Relaxer

(Answer on page 173)



5. Russian foreign minister
6. Greek goddess of vengeance
7. Worsen
8. Blessing
9. Harvard virologist, sharer of 1954 Nobel Prize for polio research
10. Nerve center involved in severest polio cases
11. Man's nickname
12. Bodian and Howard _____ concluded that polio virus belonged to 3 types in respect to immunity
13. Malabar linear measure (Pl.)
21. Roller _____ Technic, mass production method of growing polio virus
23. Denoting renal pelvis (Comb. form)
25. Dropsy
27. Caustic rod for insertion into tumor
28. Hanging device
29. Sum
30. Lost (obs.)
32. Source of succus limonis
33. Expiate
34. Marginal growths of liquid bacterial colony
36. "Medical _____", G.P.'s monthly journal
42. Tumorous neuroglia disease
43. Mature elvers
45. Salt of sulfuric acid
46. _____ Pelvis, Pelvis minor
47. Frederick C. _____ sharer of 1954 Nobel Prize for polio research
49. Leptus autumnalis
52. Misery (Arch.)
54. _____ Mamelonne, chronically inflamed gastric mucosa
55. _____stoma, Dry mouth
56. Hammon, and Yale's _____ showed polio to be as old as civilization
57. Novel by Jane Austen
59. Rake
60. That one (Fr.)
61. Man behind history's biggest "monkey business"
64. _____ encephalon, mid-brain

**in cardiac edema of
varying severity**



**weight loss ranged
from 4 to 45 lbs. on**

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Sackner, M. A., Wallack, A. A. and Bellet, S.: Am. J. M. Sc. 237:575, (May) 1959.

“The severity of the congestive heart failure . . . was as follows: Class IV (9 patients), Class III (5 patients), and Class II (1 patient).” . . . “Weight loss ranged from 4 to 45 pounds over a period of 3 to 17 days with an average of 2.4 pounds a day.”



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*Unsigned letters will neither
be published nor read.
However, at your request,
your name will be withheld.*



Slides, Please

Please advise me where I can get microscopic slides in preparation for the Board of Internal Medicine and for Surgery. You published an article sometime ago with the statement that the Navy Hospital in Washington, D. C., loaned them. Please give me the address.

ST. GARSTKA, M.D.

BAKERSFIELD, CALIF.

• *I believe the information you referred to was contained in our article "How To Get Ready For Your Surgical Boards" (Dr. E. M. Barsamian, June, 1959). Teaching slides are available from the Armed Forces Institute of Pathology, Washington, D. C. The slides are available without charge for two weeks.*

Since there's great demand for these slides on a loan basis, we

suggest that you allow 3 to 4 weeks for delivery from the time of your request.

Trauma Definition

Referring to your October, 1959 issue, Vol. 5, No. 10, page 190, question 3(E), "Traumatic injury," I feel that this term is redundant, inasmuch as my Stedman's Medical Dictionary (1953 Edition) defines "trauma" as being derived from the Greek "a wound; injury inflicted" and translated means "relating to or causing wound by injury." Thus, by definition, an injury must be traumatic.

O. L. GERICKE, M.D.

PATTON STATE HOSPITAL
PATTON, CALIFORNIA

• *You're right, of course, and thanks for setting us straight.*

—Continued on page 38

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—Continued from page 32

Mediquiz

I have read the "Mediquiz" in Volume 5, Number 9, September 1959, and on question 9 of this quiz (Most children with coarctation of the aorta) "do not have symptoms" is given as the correct answer.

I regret to advise that I cannot agree with this answer because I have found that most of the cases with coarctation of the aorta do complain of some kind of shortness of breath on exertion, and do have changes in the temperature of the lower limbs. Cases of *simple* coarctation do not have symptoms.

I feel that your answer is misleading, not only for me but for most of the people who follow "Mediquiz." I would therefore, greatly appreciate an answer to my inquiry as soon as possible, because—at this point—I do not know whether to believe the textbook or "Mediquiz" for the right answer.

CHRISTIAN M. BUJDUD, M.D.
GRASSLANDS HOSPITAL
VALHALLA, NEW YORK

• *This question was referred to our consultant, Dr. John W. Berg. His answer follows.*

The question was designed to

emphasize the difference between *children* with coarctation and *patients* with coarctation. Taussig in her book emphasizes the number of people in whom coarctation is an incidental autopsy diagnosis found at the end of a normal life's span. The other standard books on cardiovascular disease and surgery are unanimous in pointing out that many people have no symptoms and among those who do, most do not develop them until early adult life, all this despite the fact that the condition may be diagnosed early by a thorough physical examination. The wording of the question is the same as the statement on the subject by Gibson and Eisenberg in Grulee and Eley's "The Child in Health and Disease." A similar statement may be found in Brenneman's "Practice of Pediatrics." All these authorities imply that a *symptomatic* series of children with coarctation cannot be representative of the entire population and that the "well" children in that population are not getting completely adequate physical examinations.

JOHN W. BERG, M.D.
MEMORIAL CENTER FOR
CANCER AND ALLIED DISEASES
NEW YORK, NEW YORK

—Continued on page 42

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Address.....

—Continued from page 38

Draft and Residency

After reading your article about draft chances for foreign born physicians (Vol. 5, No. 3, March, 1959) I would appreciate a reply to my inquiries.

The article states that all immigrant physicians are eligible for military service regardless of whether they are licensed as yet. I have made various tries to be accepted in a military hospital as a resident but I have been refused the privilege of serving my adopted country.

I am a graduate of the medical University of Budapest, also known as "Paz-many Peter" University, in 1951 and have a Hungarian specialist diploma in clinical pathology.

In the United States, I interned at Lakewood Hospital, Cleveland, Ohio, and I was a resident in Doctors' Hospital and also Highland View Hospital. I am 32, married, with 2 children. I have my first papers and I am eligible for citizenship in 1961.

Any advice and aid you can give will be greatly appreciated.

ROBERT M. WORLE, M.D.
CLEVELAND, OHIO

• By "eligible for military service," is meant "eligible for draft by the Armed Forces." **Volun-**

teers—including Armed Service residents—are selected only from among citizens, and many of these are not accepted in the residency programs.

New Mediquiz

I have your first "Mediquiz" booklet of 150 questions and answers and have found it extremely useful. I am wondering if you are planning to put out another such booklet. Please accept the \$1 enclosed and enter my order for one if you are . . .

JOHN V. WHITE, M.D.

CLEVELAND, OHIO

• A second "Mediquiz" booklet, with 150 questions, answers and references prepared by the Professional Examination Service of the American Public Health Association, has just gone to press. Available first come, first served, we have sent you the first copy. Others interested may simply send their name and address with \$1 to the above-named association, Department 23-A, 1790 Broadway, New York City 19, New York. Be sure to specify "Volume 2." We will mail them out for as long as the supply lasts. (A few copies of "Volume 1" at \$1 are available for those who missed out.)

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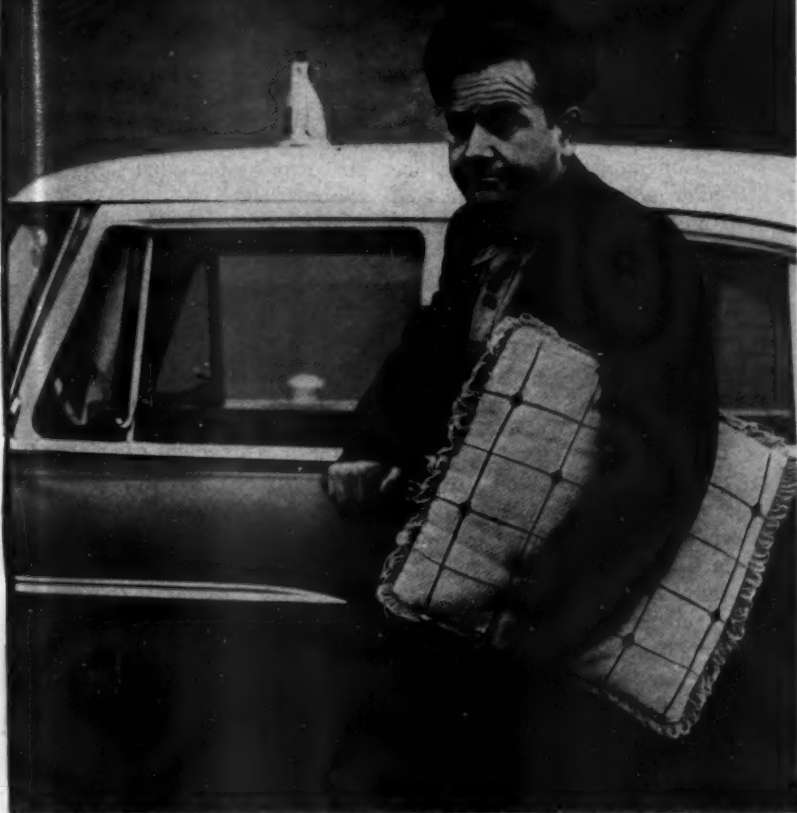
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anorectal comfort in minutes For full symptomatic control in hemorrhoids, proctitis and pruritus *ani start* treatment with 2 Anusol-HC suppositories daily for 3 to 6 days to eliminate all inflammatory symptoms rapidly and safely. Then *maintain* lasting comfort with 1 regular Anusol suppository morning and evening and after each bowel movement. Neither product contains analgesics or narcotics, will not mask serious rectal pathology.

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WARRER CHILCOTT

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—Concluded from page 42

Papers, Papers . . . I

Congratulations on your fine guest editorial "Creativity and Research," authored by Gardner Middlebrook, Director of Research & Laboratories, National Jewish Hospital, Denver.

In the past seven years I have had the privilege of visiting quite a few medical centers both in the U.S.A. and in Western Europe. During the same period, it was my privilege to attend several world congresses of various specialties. At one world congress, in London, where English is the native language, an "alleged" original paper was communicated (simultaneously carried in five languages by radio) in which the American scientist could hardly pronounce intelligibly many words of his paper. At the end when questions were in order, this doctor could not answer the questions at all. In fact, he showed no comprehension of the paper he had just communicated. Fortunately, but equally embarrassing, his chief was in attendance, and he arose to cover the deficit.

It was my privilege to personally know this great researcher-physician. When I asked him that evening why his research assistant had failed to show a fa-

miliarity with his presentation, the scientist simply said that there were more research dollars available than brains—that those research dollars demanded "papers," not quality of research! Apropos of this, one teaching center recently covered in your fine journal, stated that all of its interns and residents were required to "grind" out some research paper, usually published in one of the national medical journals. This might explain the mediocrity of the current voluminous medical literature—possibly 1 percent of which will survive.

To further aggravate this situation, but to add credence to Dr. Middlebrook's plea, only recently we were reviewing "problem" cases in a medical center — a teaching one, if you please—and the head of this university teaching center said, "If any of us see Dr. F——, tell him that we have found the original article written in 1942 which was the basis of his original research with us in 1958!" Ruthless, maybe, but realistic.

Russia takes time to screen the "stipend hunters" from the people who have ideas and a little logic to back them up. Should we do less?

F. DANIEL SUTTENFIELD, M.D.
DAYTON, OHIO

Perrin H. Long, M.D.



Editor's Page

The Peripatetic Resident

Much steam may be generated among residents when the respective advantages of static and peripatetic residency come up for discussion. Of course there are certain types of residency educational programs in which this question rarely arises. Most surgical residencies are outstanding examples of static residency programs, the reason being that graduate education in general surgery is in the nature of an apprenticeship in which the neophyte sits at the feet of the master and learns his ways of thinking and his skills. That this is true is evidenced by the fact that when one is talking of younger surgeons, one frequently hears, "He is a Blalock man, an Ochsner man, or a Churchill man;" and when one hears this, it is not difficult to conjure up in one's mind, the patterns of thinking and the techniques which these younger surgeons will exhibit. The same is also true in the surgical specialties, and in obstetrics and gynecology. It shows clearly that in surgery it is not so important where the man had his graduate educational program, but rather *who provided it for him*.

It is in the field of internal medicine that the peripatetic

resident is generally found. Now the question may be raised, is moving around, year by year, in one's residency program valuable? Protagonists of this idea point out that by doing so one gets into a new environment each year, thus being exposed to new ideas and techniques and that the resident can in three years, winnow out the best of his experiences and emerge a superior individual.

The question is whether this point of view is correct. To begin with, in medicine, the educational program does not approach an apprenticeship to the same degree as it does in surgery. Patterns of thinking are more uniform, and techniques more stereotyped. The graduate (or survivor) of a residency program in medicine is much more likely to be spoken of as a Brigham, Hopkins, or Barnes Hospital man, than as a product of the chief of the medical service in any given hospital. In other words he is a product of the hospital's educational program rather than of an individual school of thinking and doing. His personal identification is much more likely to be with the hospital. It can be easily seen that if the resident spends each year of his residency training in a different hospital he ends up without any real identification with a continuing educational program. Furthermore, he probably has few loyalties to any one of the institutions in which he received his graduate education.

As residency educational programs are supposed to develop judgment and maturity in young physicians by increasing their responsibilities, there is always the danger that the peripatetic resident will be considered a "first year" man in each new environment which he enters, and hence his opportunities for the development of judgment and maturity will be less. Furthermore, as educational programs in internal medicine at the graduate level are, or should be developed with the idea that they will afford a continuing and enlarging pattern of education, the peripatetic resident is bound to have an uneven educational experience.

Finally, the resident must think of his future in terms of hospital appointments. The graduate who has had his educational experience in one residency program certainly can be more easily evaluated by credential committees of hospitals. This is very important; he should have the benefit of the continued backing of his chief of service in his efforts to obtain his subsequent hospital appointments.

Perrin H. Long.



Advanced Education for Ge

The theme of this conference, "Medicine: A Lifelong Study," is well chosen. If medicine is to be practiced at its best and enjoyed the most, it must be a life-long study. This section will be concerned in the next few days with that part of postgraduate study relating to general practice and the various specialties. The chief questions to be discussed will probably be:

1. What forms of full time education are most useful in the years immediately following graduation or medical qualification, and how long should they last?
2. What is needed to encourage a man to continue to educate himself during the whole of his professional life?
3. Will he need educational boosts from time to time, and if so, in what form, and for how long?

Having answered these questions, we shall no doubt consider

the practical steps of organization and finance.

Objectives

Postgraduate education is built upon the basic structure of the undergraduate curriculum. This curriculum is being considered by another section of this conference. I shall assume that it will be agreed that this curriculum should be primarily educational in its objectives, and that it shall have given the student the following:

- The habit of mind of learning for himself.
- An acquaintance with scientific method.
- A nodding acquaintance with the outlines of science, particularly those relating to human biology.
- A grounding in the discipline of clinical examination, that is to say history taking, physical examination, and the use of special tests.

or General and Specialty Practice

Sir George Pickering, M.D.

- An elementary acquaintance with the phenomena of disease.

Area needs

In discussing how we are going to build on this foundation, I shall not in this address attempt to enter into detail. That is for the proceedings of the next two days. There are several certain broad considerations of which I may remind you. The first is that the needs of different geographic areas are not of the same order. For example, it is important for the general practitioner in Europe or the United States to be familiar with the acute abdomen, infantile paralysis, when a patient is ill, and with the elements of psychiatry.

In a tropical country, where acute appendicitis is rare, and psychiatry problems, though present, are unobtrusive, he must chiefly know the acute specific fevers and the methods by which transmissible disease is spread.

Sir George Pickering, Regius Professor of Medicine, University of Oxford, presented this paper at the Second World Conference on Medical Education, August 29—September 4, 1959. It will be published in the *Proceedings of the Conference*. Advance publication in *RESIDENT PHYSICIAN* is through the courtesy of the World Medical Association.

Again, techniques such as cardiac catheterization, electroencephalography and psychoanalysis, though important for specialized practice in the United States and Western Europe, are not at present of much importance in tropical countries.

It is unnecessary for me to dwell on this topic, since one of the uses of international congress is to have representatives from various parts of the world who can tell one another their problems, and thus help to put these in perspective.

Content, aims

My most important point can perhaps best be put in the form of a question. In discussing the arrangements that are necessary for postgraduate education in the fields allocated to us, are there any general principles which we must strive to maintain? I would answer without hesitation, yes.

Before mentioning these principles it will be useful to consider what is the content of postgraduate education in our fields. I would like to suggest that it is contained in the following aims:

- First, to make the doctor familiar with the kind of material with which he is going to work.
- Second, to acquaint him with those aspects of general science which will be especially useful to him in the field of knowledge which he has chosen. For example, biochemistry for those who intend to study the metabolic diseases; the physiology and pathology of the circulation for cardiologists; neurophysiology and animal behavior for psychiatrists. And perhaps genetics, epidemiology and psychology for the general practitioner.
- Third, it must acquaint him with special techniques which are proving and have proved useful in the practice of medicine in his particular field.

Precise thought

In deciding whether there are any special general principles which we ought to insist upon during these exercises, we obtain our cue, I think, from the theme of this conference, *Medicine: A Lifelong Study*. If we are to achieve this aim, our most important achievement will be to ingrain firmly a habit of mind.

I would like to suggest, therefore, that whatever the particular aspect of postgraduate education with which we are dealing, we should insist on the following two principles:

- *Precision of thought*, particularly as expressed by precision of language.

I see this as the major problem of medical education today. The function of language is to convey meaning, and we should all insist that when we write or speak, the words we use convey to the recipient precisely what we intend them to convey.

Avoid jargon

This implies first that we should avoid, as far as possible, technical jargon which has meaning only for the initiated few; second that we should examine our own language to be quite sure that we know what we mean to say and that we say what we

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mean, and third that we should insist on the same standards in the student, undergraduate or postgraduate. I cannot emphasize too strongly that I regard the inculcation of the habit of exact thought, as exemplified by precision in speaking and writing as of far greater importance in making medicine a lifelong study than courses which set out to provide the student with a mass of technical information which he has to learn by rote.

- Second, I would suggest, we must throughout *emphasize meth-*

od. In discussions on medical education it is often said that one must teach general principles. I am never clear as to what the difference is between a general principle and a basic prejudice, apart from the whim of the assessor. But I am clear about method as a habit of mind, and I would like to close by emphasizing Karl Pearson's words, "The true aim of the teacher must be to impart an appreciation of method rather than a knowledge of facts," for method is retained when facts have been forgotten.



What I Learned Ab

Here is a common sense guide for late evening house calls, practical tips on what to expect, and what to carry in your bag when making your nocturnal rounds.

Maybe you think you'll be different—and that nobody will ever find you running around in the middle of a rainy night with your black bag and flashlight trying to find some obscure street address. Not so.

If yours is an average beginning

practice, you'll welcome night call income to pay your bills while your office practice develops. Maybe six months. Maybe two years. But like it or not, chances are you'll be taking your share of night work.

Advantages

Actually, there are many advantages for the beginning doctor in handling emergencies after regular hours. Skipping the obvious (income), the self-confi-



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ed About NIGHT CALLS

Morris Soled, M.D.

dence such calls give to the young doctor is an important benefit. Barring a series of catastrophes among your first few night calls, this is a sure way to develop confidence in yourself and your training—right on the firing line.

Patients

Another advantage: night calls are a source of patients for your daytime practice. Where you are covering for another doctor, most of your night call patients aren't going to switch from their regular doctor to you (and in many cases you couldn't ethically accept these patients). Still, they will refer their friends to you, if your attitude and efficiency impress them, *because of your willingness to make night calls.*

Other doctors

How do you get night calls early in your practice? Easy. While arranging to enter practice, make the rounds of physician col-

leagues in the neighborhood to introduce yourself and get acquainted. At that time simply mention "I'll be happy to take your night or weekend calls for you if ever the need arises."

You'd be surprised how many doctors are anxious to find a qualified physician willing to take night and weekend calls.

If a doctor indicates his intention to refer calls your way, it's proper to ask his fee for night calls so that you can charge the same fee.

Answering service

A second source of night calls is your telephone answering service. Tell them you're available. Many doctors looking for an evening off, ask service, "Who's available for the night?"

Also notify

- medical society
- hospital
- telephone company
- police and fire departments

Before long you'll have all the night calls you can handle.

Pain, anxiety

When you take a night call, remember this:

- It is the time of day when the patients wants and needs sleep.

- Pain is intensified because there is nothing to divert the patient's attention from it.

- Fever is apt to peak.

- The anxiety of being ill is most acute.

- Apprehension concerning a "strange" doctor is exaggerated.

This is the time when the physician needs to be most self-sufficient. Drug stores and laboratories are closed. Immediate consultation is generally unavailable, and hospital services are limited.

Thus, it is solely up to you to decide whether to place the patient in the hospital or follow the illness at home until the patient is seen by his own doctor.

Bag

Before you make your first house call you should get your equipment in order. A well-supplied doctor's bag is obviously a necessity. Remember, during the night practically all pharmacies are closed. And unless you are prepared to offer a suffering pa-

tient some medication to help carry him through the night, your visit will seem, in many cases, a waste of time.

I've included here two lists of items I have found necessary; one of articles to keep in my bag, and a secondary list of items I keep in my car trunk.

I want to make special mention of one item because it's one you may overlook. That is the quick reference list of common poisons and antidotes.

And though I didn't include it on the list, a spotlight on your car is a real help in locating house numbers and street signs. A large hand flashlight will serve (you'll need a smaller flashlight, anyway), but is a bit more awkward to handle.

Narcotics

Most drug houses have starting samples of their products available without charge to the beginning physician. Among your supplies you should have medication for the most common night call, pain. *Some type of narcotic or sedative is a must, both in injectable and oral form. Note: You will have to buy narcotics. They are never sent out as samples.*

Write everything down. If you leave the patient with a narcotic, make a note of it to use for your

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ITEMS IN PERSONAL BAG

● Instruments

STETHOSCOPE	SCISSORS—BANDAGE
OTOSCOPE AND OPHTHALMOSCOPE	TONGUE DEPRESSORS
SPHYGMOMANOMETER	SYRINGES—2cc, 5cc, 10cc
FORCEPS AND SCALPEL	THERMOMETER—ORAL AND RECTAL

● Injectables

PENICILLIN	DIGITALIS PREPARATION
BROAD SPECTRUM ANTIBIOTICS	DIURETIC
ANALGESIC	CENTRAL NERVOUS STIMULANT
SEDATIVE	ADRENALIN
ANTIHISTAMINE	50% GLUCOSE
RESPIRATORY STIMULANT	OPIATES

● Tablets or Syringes

ANTIBIOTICS	NARCOTICS
ANTIHISTAMINES	ANTIEMETIC DRUGS AND SUPPOSITORIES
SEDATIVES	SEDATIVE SUPPOSITORIES
ANALGESIC	TRANQUILIZERS

● Dressings and Equipment

BANDAIDS	URINE TESTING MATERIAL
BANDAGES	FLASHLIGHT
ACE BANDAGE	STERILE WATER
ADHESIVE TAPE	ALCOHOL
FINGER COTS	ANTISEPTIC
TRACHEOTOMY KIT	

● Miscellaneous

LIST OF POISONS AND ANTIDOTES	FOUNTAIN OR BALL POINT PEN
LOLLIPOPS	EXTRA IGNITION AND TRUNK KEYS
3 x 5 CARDS	

ITEMS IN CAR TRUNK

SUTURE SET	ASSORTED SPLINTS
SCALPEL	ASSORTED BANDAGES
FORCEPS	TEXTBOOKS
NEEDLE HOLDER	LAB BOTTLES
STERILE GLOVES	

drug inventory at the end of the year.

When you prescribe medication in the home, *give written instructions*, to prevent a mistake by a forgetful or anxious patient.

In treating fever, *write out the dosage of aspirin*.

Write out a simple diet.

Write whether or not you want hot or cold applications.

Be specific in your written directions to the patient or relative concerning how to reduce fever, give an enema. I am making special emphasis of this point because I learned the hard way that an anxious person can do some really incredible things with an oral direction.

(It might be well to tell you that if you are uncertain as to the proper method for giving an enema or an alcohol sponge, you are among a vast group of graduating residents who share your ignorance. It is a simple matter to check with one of the nurses at the hospital to get this information.)

Good medicine

Here are some things you can do—in the interest of better medicine and good doctor-patient relations:

- A suspicious throat in one member of a family normally calls

for you to examine others in the family group. If you find evidence of a contagious disease, of course, the family examination is a must.

- Tell the family what they may expect concerning the illness or reaction to the medication during the remainder of the night. Always state the indications for another telephone call to you.

- Label any medication you leave with the patient so that the patient's regular physician will have this information when he sees the patient in the morning. Also, in most cases, it is wise to tell the patient what medication he is taking.

If you write a prescription, give your patient an idea of the cost. This act of consideration is always appreciated.

Whose patient?

The question of whether or not you can ethically consider the patient your patient is sometimes difficult to answer. Here are two guiding principles:

- If you see the patient while covering for another doctor, you'll report your visit to the other doctor; the patient remains his patient. However, in a small town, you may cover most of the doctors at night and would soon limit yourself to not being able to accept any patients in the area. So,



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Fees

The question of fees sometimes poses a problem in taking night calls. First, encourage payment at the time of the call. Most of these patients will be strangers to you—you won't see many of them again. There is no long-established relationship between the doctor and the patient and often a deferred fee will be neglected. Such a simple statement as: "This will be eight dollars," or "Would you care to pay me now," frequently increases the collection rate.

Always carry change in your pocket for a twenty-dollar bill as well as a few blank checks. I have waited months for many an \$8 fee when I could have collected the night of the call, if I only had two singles to make change for a ten—or a blank check when the patient wanted to write a check.

Fair

How much to charge is not as great a problem as it seems. If a patient calls Dr. X and expects to pay \$7 for a night call and instead of Dr. X you arrive, representing Dr. X, the patient logically expects you will have the same fee.

If your fee happens to be less than Dr. X's it's still not wise to charge less. In a sense, you would be tempting the patient to switch

many doctors agree on a time limit. That is, they will not accept a patient that they have seen for another doctor for three, six, nine, or twelve months after the visit.

- If the call came to you directly from the medical society, from telephone service, hospital or police department, or from another patient, you may accept such a patient for further treatment. The very fact that the patient's own doctor was not available *and left no one to adequately cover his practice* means that he has in effect deserted his patient for the evening.

to you because of your lower fees.

The simplest thing is to charge your own fee on all patients not involving another doctor, and the other doctor's fee when covering for him.

Calls

In the morning, call the other doctors of patients you have seen. Leave word concerning who you've seen and what you have prescribed. If you are covering for the doctor, this seems obvious but even if you are not covering for the doctor you may happen to be called by one of his patients. It is good manners to inform the other doctor that you have seen one of his patients and what you've prescribed. He will appreciate your call and may be a good source of other referrals.

Followup

If the patient has no doctor of his own it's good public relations as well as good medicine to make a follow-up telephone call the next day to find out how your patient is doing and whether or not he is following your directions properly.

In no other part of medical practice are records neglected as they are as in home and night calls.

Actually, I've found the sim-

plest procedure is to fill out a 3 x 5 index card immediately after seeing the patient. A supply of cards can be carried in your bag. Include on each card the name and age of the patient, address, telephone number, date and time of the call, other doctor's name (if covering), whether or not they paid you, and a few brief notes as to what occurred, including Rx, if any.

In the morning, you can refer to the cards when calling other doctors. Then you can file them in a special area of your filing system. After the patient has paid your bill, they can be filed in your dead file—but don't discard them. Some of the night patients will come to your office later and you can refer to the card to learn the previous complaint and treatment.

When not covering for another doctor, have no hesitation in leaving your card, *if asked*. On patients that you have seen for another doctor try to avoid this. It is jarring to a doctor who has had a young physician cover him at night to come into a house on a subsequent visit and find the young doctor's card tacked on the patient's telephone note board. (If the patient wants you he'll find you. In any event, you will leave a telephone number to call in an emergency; leaving your

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card just points to your interest in stealing a patient.)

Patient care

I found night calls a good source of patients, an aid in the beginning private practices, and a lesson in self-confidence. A correct diagnosis in the dark hours

of the morning, alone, without consultation, without a laboratory, without a house staff to back me up, was satisfying to say the least.

You'll learn one more thing: If you can practice good medicine in the home, you can practice anywhere.

NEWS ROUNDS

GP Training Set

Family Doctor Training—A two-year training program for aspiring GPs has been set up at Indiana University Medical Center. Beginning with a special orientation in emergency room, medicine, pediatric, psychiatric, and obstetric services, the trainee will be given supervised experience in clinics and hospitals. During outpatient clinic duty, the trainee will follow his patients through other medical services and will assist in their care whenever they are hospitalized.

Note-Taking for Keeps

Lynn T. Stahell, M.D.

**Simple, yet practical,
your filing system
can also be portable.**

During medical school the textbook serves as the major source of information. It also functions as the basic reference. But, in the postgraduate years, journals, conferences and medical conventions are added as primary sources of information. And since this information, by its nature, is usually unavailable for ready reference, a personal reference file is desirable.

The physician who records and files important points from his reading and conferences will be able to keep most of his past medical knowledge at his fingertips.

Characteristics of a practical system should include:

- *Portability*—must be available when needed.

- *No Transcribing*—may be filed in original form.

- *Easily Filed*—standardized so filing is rapid.

Other requirements which add to the value of your reference file are: adaptability for use in teaching, low cost, and compactness.

Method

One method of note-taking and filing which meets all of these criteria is the use of the 5 x 8" note card. As a freshman in medical school the use of 5 x 8" cards was

ABOUT THE AUTHOR

A graduate of the University of Utah, the author is presently taking a straight medical internship at Salt Lake General Hospital.



Fig. 1 A 5x8 inch card showing major heading, date and vertical line dividing card into two columns.



Fig. 2 This small, two-drawer file will hold up to 3,000 5 x 8 inch cards.

FILE HEADINGS

MAJOR

- 0—Body as a whole
- 1—Integument
- 2—MS
- 3—Respiratory
- 4—CV
- 5—Hem. & Lymph
- 6—GI
- 7—GU
- 8—Endocrine
- 9—Neuro
- x—Spec. senses

ETIOLOGICAL

- a—Anatomy*
- p—Physiology*
- 0 Prenatal influences
- 1 Lower plant & animal
- 2 Higher plant & animal
- 3 Intoxications
- 4 Physical agents
- 5 Circulatory disturbance
- 55 Innervation of psychic disturbance
- 6 Static mech. abn.
- 7 Dist. of metabolism
- 8 New growth
- 9 Structural reaction
- x Functional reaction
- y Undetermined cause

*added for convenience

Based on Standard Nomenclature of Disease

recommended by our anatomy professor. I took the suggestion and during the past five years have found this method practical and convenient (Figure 1).

Tips on use

In using the 5 x 8" card I have found it most convenient to write and underline the major headings in the upper left-hand corner. Next is listed the date and information source. Dividing each side of the card into two columns will usually save space—especially when outlining.

When there isn't time to file the cards written for the day, I usually place them in the front of the

file and when time allows, file the cards and review important points.

It is surprising how much information can be brought out of a "nearly forgotten" status into a useful plane of memory with even a brief review a few days after the notes are recorded.

Filing

Many forms of containers for filing cards are available. These range from the 15c cardboard folder to the metal or cardboard box type of file. Metal drawer files are more expensive; they cost about \$6 for a single or \$10 for a two-drawer file. A single drawer

will hold about 1500 cards. I have all of my medical school notes contained in a two-drawer file which measures about 7" x 18" x 16" (See Figure 2).

Headings

The way notes are classified is an individual matter. For example, the headings needed for filing the notes of an Ob-Gyn resident would be entirely different than for the neurosurgeon. There are several good ways of arranging the file.

STANDARD NOMENCLATURE OF DISEASE. In this system (see table) the organ systems are major headings. These are subdivided into categories of different etiologies. Simple addition of two more subdivisions, "a" for anatomy and "p" for physiology, makes this a very suitable pattern. For a more detailed description see the book entitled *Standard Nomenclature of Disease*. This wide range, incidentally, would be especially suitable for the general practitioner.

TEXTBOOK HEADINGS. Especially valuable for those in the specialties, the textbook headings and organization of Harrison's or Cecil's texts can be used by the internist, Christopher's or Allan's text for the surgeon. For other specialties a comparable selection of a comprehensive, well-organized textbook will provide a good basis for file headings.

ORIGINAL HEADINGS. Often necessary for the researcher or the individualist, original headings are generally not advisable since it becomes a problem to remember your own headings after a few years.

With a very little effort this system can be of great value in your medical career. Although it is very useful in medical school, its portability and simplicity gives it even added value during residency and practice. This is especially true because information is less frequently obtained from textbooks in later years, and carrying a looseleaf is no longer practical.

A fast-growing specialty

Specialists Wanted: Physical Medicine

Physical Medicine and Rehabilitation is among the newest of the recognized specialties of modern medicine. It has become an integral part of medical practice only in the past few years. Yet the specialty is in one sense the oldest medical specialty since it utilizes physical agents in the treatment of disease, a form of therapy employed by earliest man.

Total care

Physical Medicine is the use of physical therapeutic agents such as heat, water, electricity, exercises, etc., in the diagnosis and treatment of disease. Rehabilitation is the developing of a person to the maximum of his capabilities within the limits of his disability. Rehabilitation is not only physical rehabilitation but vocational, educational, social, and in some cases even religious. Thus, the specialty is one which involves total patient care.

The increasing need for physiatrists has put the PM & R doctor in the "most wanted" category in hundreds of communities.

Peter D. O'Loughlin, M.D.

Combined

For example, in the treatment of rheumatoid disease it has often been said that drug therapy without physical therapy is grossly inadequate. Some form of therapy to alleviate pain, prevent weakness and deformity is as essential as the judicious use of salicylates and steroids.

Also, in diseases of the cerebral vascular system, studies indicate that 90 percent of hemiplegic patients can walk if exercise ther-

Physical Medicine and Rehabilitation

apy is begun early. The patient with the myocardial infarct or other severe cardiac disability must be gradually progressed to an active program. This is most effectively administered in the hospital by putting the patient on a graduated program of exercises.

Physical Medicine and Rehabilitation is a part of the care of the amputee. The patient who receives a prosthesis without training will never realize the full function of the device.

Most patients with orthopedic problems need physical therapy. (In this hospital almost all the orthopedic patients are receiving some type of physical therapy.)

Diagnosis

In the field of diagnosis the role of the physiatrist is frequently overlooked. Yet, he is trained to interpret in the vast field of electro-diagnosis. He uses various diagnostic procedures such as skin temperature studies, low voltage testing and electromyography. The latter, a relatively new field, is becoming more and more in demand. The physiatrist is skilled in disability evaluations, and in the general diagnosis of neuromuscular and musculoskeletal disorders.

Often a patient's problems are of a social and occasionally even legal nature, as in the case of

About The Author

Receiving his M.D. from Marquette University in 1955, the author completed his internship (1957) and a one-year residency in pathology at St. Mary's Hospital, San Francisco, California. He is presently in his third year of PM&R residency at VA Hospital, Wood, Wisconsin. Dr. O'Loughlin

is the author of "Bowen's Disease of the Anus" published in the December 1958 issue of *California Medicine*.

incompetency judgments. The doctor in Physical Medicine and Rehabilitation is familiar with the aid that social service can provide in helping with family problems. Vocational counselling is frequently needed to assist the handicapped patient in getting a job. The physiatrist coordinates the entire care and rehabilitation program, and is the patient's doctor.

Physical agents

Obviously, a doctor in Physical Medicine and Rehabilitation must be familiar not only with drugs as therapeutic agents but also with the different types of physical modalities used in therapeutics. New advances are constantly being made in the use of ultrasound, short wave diathermy, and other procedures which are extremely useful in many cases. However, these too have limitations as well as contraindications. The correct amount of therapy helps; too much therapy can be harmful. For instance, ultrasound is an extremely useful therapeutic tool. Yet, excessive ultrasound can destroy tissues instead of promoting healing.

There is a growing demand for physiatrists in all parts of the U.S. at present. Many private hospitals are developing departments of Physical Medicine and

Rehabilitation, but there are few trained doctors to head these departments. A young physiatrist can choose his own location almost anywhere in the U.S. and obtain staff privileges because his specialty is in demand.

Residency programs

Currently, a total of 66 hospitals offer 318 approved three-year residencies in PM & R. Bellevue (New York University Division) increased its program from 13 in 1957 to 69 in 1958.

About one-third of the residency programs in Physical Medicine and Rehabilitation are in Veterans Administration hospitals, and many of these are associated closely with medical schools.

Programs include certain aspects of the basic sciences as well as the clinical experience in physical disabilities related to the fields of rheumatology, neurology, neurosurgery, orthopedics and medicine.

Also involved in the residency experience is a knowledge of the roles of physical therapists, occupational therapist, clinical psychologist, social service worker, and vocational guidance counselor.

As an incentive to attract physicians into the field, there are several types of plans which offer

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considerable financial assistance to the PM & R resident.

The career program offered by the Veterans Administration is one answer to the problem of finances while still in training. Also, in the non-Veterans Administration hospitals grants are available for training. The National Foundation and the Office of Vocational Rehabilitation offer grants for residency training in the specialty.

Physical Medicine and Rehabilitation is a challenging new

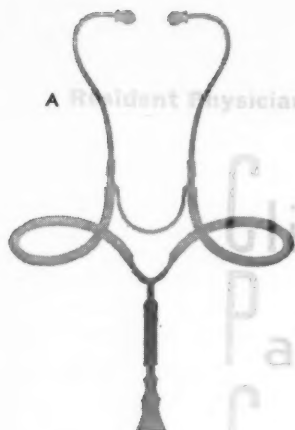
specialty. With new advances constantly being made in this field, the demand for young physicians trained in this specialty is growing. Aid programs offered by various groups assist the resident in Physical Medicine and Rehabilitation to be financially independent while in training.

Most important, the work itself is extremely interesting, the patients' gratitude warming. Certainly, the personal satisfaction gained is a significant reward for the PM & R doctor.

NEWS ROUNDS

U.S. Longevity Tops U.S.S.R.

To Your Health!—The differential in life expectancy between the U.S. citizen and the Russian amounts to about 4 years—in favor of the U.S. Despite frequent Soviet reports to the contrary, U.S.S.R. mortality, after taking into account age and sex distributions, is about 25 percent higher in the aggregate than that of the U.S., while fertility is about 24 percent lower, according to Robert J. Myers, chief actuary of the Social Security Administration, reporting in Public Health Reports.



A Resident Physician MONTHLY FEATURE

Clinical Pathological Conference

Highland-Alameda County Hospital

E.H. MEXICAN MALE. AGE 17.

ADM. 3-4-58. DIED 3-12-58.

This 17-year-old Mexican schoolboy had been "perfectly well" until November of 1957 when he had a 3-day episode of headache and malaise which was thought to be the "flu." He returned to school, but came home early on a few occasions complaining of easy fatiguability. In December he was taken to a local physician who treated him for complaints of "flu" and in January he had several episodes of vomiting yellow material.

Late in January he complained of headache and retrobulbar pain followed by transient periods of numbness, and crampings in his arms and legs. Approximately 6 days prior to his present admission, malaise

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increased and was accompanied by episodes of vomiting and numbness of his extremities. On day of admission he was noted to be confused and disoriented. He had a generalized convulsion at home. Several days prior to entry his doctor had found Hgb. 40%; RBC 2.1 million; NPN 45 mgm%; 3+ ceph. flocc., 2+ albumin in the urine. An eye consultant observed a retinal hemorrhage in the right fundus. The patient had received several shots of penicillin in December for the "flu" episodes mentioned above.

History

Past History. Seasonal occurrence of "hives," otherwise the past history was completely negative.

Family History. One of the patient's sisters had an "allergic" condition which was not otherwise delineated. There was no history of kidney disease, anemia, bleeding, easy bruising, or any other serious illnesses.

Physical Examination. On admission examination revealed a thin, young male who moaned and picked at his bed clothes, talked incoherently and only responded slightly when his name was called. Rectal temp. 101 F. Pulse 108. Resp. 24. BP 138/78. The skin showed no pete-

chiae; there was no adenopathy or upper respiratory inflammation. Examination of fundi at that time was unsatisfactory. The neck was not stiff. A Grade I low pitched systolic murmur was heard, best at the apex, and the lungs were clear. Liver, spleen, and kidneys were not palpable. The deep tendon reflexes were hyperactive bilaterally, and a sustained ankle clonus was present bilaterally.

Five hours later the patient was deeply comatose, responding only to deep pain. His head and eyes were deviated to the right with an associated left hemiplegia, a left central facial paralysis, and an intermittent coarse tremor of the right arm and leg.

Laboratory studies in the emergency room revealed a WBC of 20,400 with 90% polys, 8% lymphs, and 2% monos. There was mild anisocytosis. A urinalysis showed a specific gravity of 1.013 with no sugar, 4+ albumin, and a few RBC's. There were no casts. The spinal fluid was clear with 12 RBC's/cu.mm. and no xanthochromia. Chest and skull x-rays were unremarkable. Patient at this point was admitted to the medical ward with a diagnosis of possible brain abscess.

Hospital Course. The patient

was given 1 unit of whole blood the first night because of his marked anemia and in preparation for possible surgery. Examination on the following morning revealed additional physical findings which included 2 discrete retinal hemorrhages and several small petechiae on trunks and legs. It was felt that the disease was a generalized process involving the kidney, brain, and possibly other organs. The thought of surgery was dismissed at this time.

Multiple blood cultures were drawn which later proved to be negative and the patient was placed on 15 million units of penicillin daily.

Second day

Laboratory results on the second day of admission were as follows: WBC 15,500; Diff. 80% polys, 18% lymphs, 2% monos; Hgb. 6.2 gm; RBC 1.57 million; PCV 17%; Wintrobe Indices were MCV 86, MCH 31.5, MCHC 37%; Icteric Index 18; Retic. count 19%; bleeding time 9 minutes; clotting time 6 minutes; BUN 55; Platelet count, 45,000/cu. mm. Urine: 150-250 RBC/hpf. Bone marrow aspiration revealed erythroid hyperplasia and megakaryocytosis. Platelet production did not seem to be diminished.

On the second day the patient had an episode of hematemesis of coffee ground material. Scleral icterus was noted along with ecchymoses and bleeding from the gums. The patient remained comatose. Rectal temperature ranged from 101° to 102° F.

On the third hospital day, the direct Coomb's test and L.E. prep. were negative. ACTH, cortisone, hydrocortisone, and chloramphenicol were added to the therapeutic regimen.

Transfusions

Despite 8 blood transfusions during hospitalization, there was no significant change in the hemoglobin or platelet count. However, he gradually regained consciousness during the next 3 days. His febrile course persisted with rectal temps. of 100°-103° F. and his hemiplegia gradually improved. Bleeding time on cortisone returned to normal and no new bleeding was noticed. Despite the normal bleeding time, examination of peripheral blood revealed almost no platelets.

On the 5th day of admission, skin, muscle, and bone marrow biopsies were done. These failed to reveal any new information. Six days after admission the patient became confused, lapsed into semicoma with Cheyne-

Stokes respirations. He expired on the 8th day after admission.

DR. HENRY LEBOST, *Assistant Resident, Radiology; Highland-Alameda County Hospital*. The heart size is at the upper limits of normal. The vascular markings, lung fields and bony thorax are not remarkable. Films of the skull demonstrate a normal appearance of the calvarium, vascular markings and sella turcica. A calcification noted on the lateral and Towne views, is assumed to be pineal, and is in normal position. There also appears to be some calcification in the left choroid plexus in normal position. The right plexus is not visualized. There are no localized erosions, or areas of hyperostosis in the skull to suggest a chronic subdural hematoma, although an acute lesion could be present without having produced these changes. In K.U.B. films the kidney shadows are outlined in anatomical size, shape and position with the upper pole in this examination slightly above the 12th rib posteriorly and extending with the lower pole at the transverse processes or slightly beyond the third lumbar vertebra. Urinary calculus is not apparent. The bony structures appear normal.

DR. ELI MOVITT, *Chief, Medical Service Veterans Administra-*

tion Hospital, Oakland. Associate Staff, Highland-Alameda County Hospital. The case is that of a 17-year-old boy whose illness ran a very stormy course during the period of hospitalization and swiftly terminated in death a week after admission. This illness, however, seems to have begun at least four months before entry with symptoms which were originally interpreted as those of a "flu" or "flu-like" state characterized by headache and malaise.

Beginning

Although the patient seemingly recovered from this within three days and even went back to school, quite apparently it was only a beginning of what proved to be a serious and fatal illness. Thus the boy, following the three-day period of "flu-like" symptoms, developed easy fatigability, perhaps over and beyond just merely a post-influenzal asthenia, had several spells of vomiting, bringing up some yellow material; and in addition, and in rather rapid succession, became subject to still more headaches, retrobulbar pain and transient episodes of numbness and cramping in all four extremities.

Later there were added other developments such as mental con-

fusion, disorientation and finally a generalized convulsion which brought him into the hospital.

Nervous system

Thus, the salient features have become neurological ones, making one think of some kind of central nervous system involvement, for example a brain tumor; or, still better, a brain abscess because of the associated fever and leukocytosis.

In fact, the patient was being prepared for an operation soon after entry and one would be inclined to believe that the surgical procedure then contemplated was with this thought in mind.

But no sooner do we start entertaining this possibility of a brain tumor or a brain abscess than we come across certain data that make this diagnosis less likely.

Generalized

We are told that the patient's private physician found marked anemia, elevated blood urea nitrogen of 45 mgm%, proteinuria and a positive cephalin flocculation test. We would not ordinarily expect to see all this in association with the two conditions I just mentioned.

Perhaps a slight degree of

azotemia could be explained by protracted vomiting causing a so-called pre-renal azotemia.

Possibly, also, proteinuria could be ascribed to the same cause; but marked anemia and a positive cephalin flocculation test would remain unexplained.

Because of the severe anemia and a positive cephalin flocculation test, we might start thinking of nervous system involvement as representing some generalized disease process and true enough, we find support for this thought in what follows in the protocol.

Neurological

It is interesting to note that the neurological findings are multiple, diffuse, rather bizarre and some of them transient — consisting of hyperreflexia, bilateral ankle clonus, deviation of the head and eyes to the right, left facial weakness and left hemiplegia, intermittent coarse tremors of the right arm and leg and variable state of consciousness, with the patient lapsing into coma and then regaining consciousness at least temporarily, with hemiplegia improving at one time.

In addition to these neurological manifestations there were the following pertinent physical findings: fever, Grade I low

pitched systolic murmur, heard best at the apex, retinal hemorrhages and petechiae over the trunk and legs.

Bacterial?

Here we have all we need for the diagnosis of subacute bacterial endocarditis. Anemia and leukocytosis will go well with this diagnosis, and to these we may add the neurologic manifestations and the renal involvement manifested by proteinuria, hematuria, and mounting azotemia, the blood urea nitrogen reaching at one time the level of 55 mgr. %.

Glomerulonephritis is one type of renal involvement in this disease, though it is a rarer type of involvement. Sometimes it even becomes a most prominent feature of subacute bacterial endocarditis and may then be mistaken for the primary disease. Neurological symptoms and signs would be of course of embolic origin.

True enough, a definite diagnosis of an organic valvular defect on the basis of only Grade I apical systolic murmur cannot be made, but there are cases of subacute bacterial endocarditis without any murmurs at all. One knows of at least three reasons for this occurrence: the murmur should have been heard but was

not; the valvular defect is at least part of the time acoustically silent; or the lesion is extracardiac.

It is probably with this thought in mind about possible subacute bacterial endocarditis that multiple blood cultures were drawn and penicillin therapy instituted, in spite of the negative results of these cultures.

Hemorrhagic

But at the same time, there is too much in the protocol against the diagnosis of subacute bacterial endocarditis in addition to the problem posed by negative blood cultures which otherwise might be thought to represent the non-bacterial stage of the disease. In the first place, the neurologic side of the picture is somewhat too bizarre to be interpreted as being due to an embolic phenomenon. Nor do the petechiae seem to be of that origin.

We see that the patient had thrombocytopenia, and this would well explain the petechiae as well as prolonged bleeding time of 9 minutes. This finding of thrombocytopenia in the blood is correlated with megakaryocytosis in the bone marrow so we know that there is adequate platelet production. Thrombocytopenia is also probably responsible, at

least in part, for an episode of hematemesis, ecchymoses and bleeding gums.

All these hemorrhagic tendencies are not usually a part of subacute bacterial endocarditis; neither is the icterus the patient developed while in the hospital. It looks like we better abandon this diagnosis altogether.

Collagen

But we are still left with the evidence of multiple system involvement, and inasmuch as it does not fit into the frame of subacute bacterial endocarditis, we can turn next to the group of conditions where multiple system involvement is so characteristic, namely, the so-called "collagen diseases," disseminated lupus erythematosus, for example. There is probably nothing in the protocol that is inconsistent with this disease. We all know that skin and muscle biopsies may be unrewarding in this condition, as they were in the case under discussion; neither do the negative lupus erythematosus cell preparations reported in the protocol rule it out necessarily any more than the positive result on this test would absolutely rule it in.

The murmur, unless it stood for nothing at all, could possibly represent the verrucous endo-

carditis of disseminated lupus, the "Libman-Sacks" syndrome, only comparatively rarely found in our day and age, in contrast to having been a common finding some thirty years ago. This is probably for the reason that the old series of lupus erythematosus were weighted by the endocardial lesion which was then one of very few sure ways of arriving at the diagnosis.

Hemolytic

Anemia is common in lupus erythematosus. Sometimes it is very severe. I saw one patient with only 3 gm.% of hemoglobin so I am not all surprised that your patient had 6 gm.%. In some patients it is a hemolytic type of anemia, as it undoubtedly was in our patient today.

In contrast to congenital hemolytic disorders where the anemia may be microcytic and hypochromic, in acquired hemolytic disorders it is usually microcytic or normocytic and normochromic.

The Wintrobe indices in this case were those of a normocytic, normochromic anemia. The slight icterus, the high reticulocyte count of 19% and particularly the inability to raise the hemoglobin's level by eight blood transfusions crowded into the period of only several days —

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unless there was more bleeding than the protocol makes apparent—all point most strongly to the presence of a hemolytic process.

Our patient also had marked thrombocytopenia on several counts. Well, some patients with lupus have this, also. In fact Dr. Dameshek lately has been preaching the gospel that some patients with lupus may have thrombocytopenic purpura as the initial manifestation of the disease and then be mistaken for the idiopathic variety. As far back as about a decade ago Dr. Rich at Johns Hopkins Hospital, reviewing cases with the initial clinical diagnosis of idiopathic thrombocytopenic purpura, uncovered a few instances of disseminated lupus.

Lupus cell

Then all in all, why should we not accept the diagnosis of this condition in our case? As I said before, there is absolutely nothing in the protocol that is in any way inconsistent with it, but on the other hand, one feels just a bit uncomfortable in stopping right here for a number of reasons.

With all that was said about the lupus erythematosus following such a fulminant course, one would like to see at least an

occasional lupus erythematosus cell, and if not a typical lupus erythematosus cell, at least a tart cell. Nothing of the sort had been found. Also, although in an angiitic process involving vessels of the brain all sorts of neurologic manifestations can be expected, here we have so many different ones in one and the same patient. Although very marked anemia, a severe hemolytic process and profound thrombocytopenia occur in lupus erythematosus, here again they are all manifested in one and the same patient, as if it were a little too much for just one case.

On the other hand, we know of a disease process where positive lupus erythematosus cell test is not needed for confirmation, where the skin and muscle biopsies, with only a few exceptions, had been unrevealing as they were in your patient; where marked hemolytic anemia and thrombocytopenic purpura almost always go together; where, in fact, a hemolytic process and thrombocytopenia are the *sine qua non* of the disease; and where everything else our patient had fits so well.

The only reason I would hesitate in making this diagnosis is that it is a comparatively new and still rare affliction, with only,

I would venture to say, several dozen cases reported to this date. I have never seen a case although I am well acquainted with this condition through the literature.

I have in mind "thrombotic thrombocytopenic purpura," a condition which on the clinical side is characterized by a triad of thrombocytopenic purpura, hemolytic anemia and neurological signs known to be as bizarre, diffuse and sometimes transient as they had been in this boy.

On the pathologic side the disease is characterized by formation of multiple thrombi in small blood vessels throughout the body. These thrombi explain the clinical manifestations of the diseases and are believed by some to be responsible for thrombocytopenia as if the platelets were consumed or caught in the process of thrombus formation; although, I understand, the pathologist has great difficulty in identifying the presence of platelets in the thrombus.

If I am allowed to make two diagnoses, I will say disseminated lupus erythematosus or thrombotic thrombocytopenic purpura. If I must make only one diagnosis, I will have to choose thrombotic thrombocytopenic purpura.

Rickettsial?

DR. EDWARD SHERRER, *Intern*. At any time was the spleen felt to be enlarged?

DR. ARTHUR SAMS, *Resident, Medicine*. No, the spleen was not palpable.

DR. MOVITT: It would not be particularly helpful as splenomegaly would still be consistent with either diagnosis.

DR. CONSTANTINE GLAFKIDES, *Assistant Resident, Medicine*. Does the 20,000 WBC sway you one way or another?

DR. MOVITT: Leukopenia and leukocytosis both occur in disseminated lupus.

DR. JOHN ALLINGTON, *Intern*. Could this be considered a rickettsial disease or infectious mononucleosis?

DR. MOVITT: The illness began several months before entry. This patient had been on broad spectrum antibiotics which should have influenced his course if he had had a rickettsial disease.

DR. MOHAMAD RAZAVI, *Assistant Resident, Medicine*. Did the patient have a high fever?

DR. MOVITT: Yes, up to 103°. Fungus infection, I believe, would explain the neurologic picture better than a rickettsial disease. I do not think that the hematologic findings, however, would go well with it.

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DR. PRESTON JAMES, *Intern*. Could the etiology of the two diagnoses that Dr. Movitt made be blamed on the fact that the patient received massive doses of penicillin?

DR. MOVITT: He received penicillin therapy in December for a "flu-like syndrome"—this may not have had anything to do with what followed. However, frequently there is a history of hives or allergic manifestation in people who later come down with thrombotic thrombocytopenic purpura and penicillin may possibly set it off also.

DR. ROBERT J. PARSONS, *Director of Pathology and Laboratory Service*. How valid is the history of hives? Most of us have had hives at one time or another. How many in the audience have had hives? I see more than 50% have such a history.

Dr. Movitt's Diagnosis: Thrombotic thrombocytopenic purpura and lupus erythematosus, or Thrombotic thrombocytopenic purpura alone.

Pathological findings

DR. PARSONS: The autopsy revealed petechiae in the skin. On opening the body, 25 cc of blood-tinged fluid was found in each pleural cavity. 155 cc blood-tinged fluid was found in the

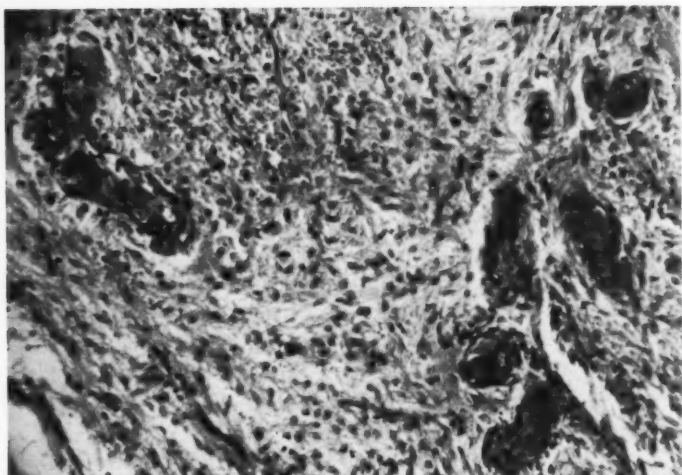
pericardial sac. The serosa of the heart was peppered with petechial hemorrhages. The serosal surface of the lungs showed no petechiae, while the serosal surface of the stomach and liver showed petechiae.

Further examination of the body showed petechiae in the heart muscle, mucosa of the stomach and small intestine, in the parenchyma of the liver, on the surface of the kidney and in the parenchyma of the kidney. They were also found at many sites of the brain.

The heart weighed 390 grams—a little large. The spleen weighed 390 grams. The spleen was big enough, under ideal circumstances to feel it; however, the abdomen of this 17-year-old patient had good musculature and it was probably not possible to get in well enough to feel it. The liver weighed 1900 grams and was considered large.

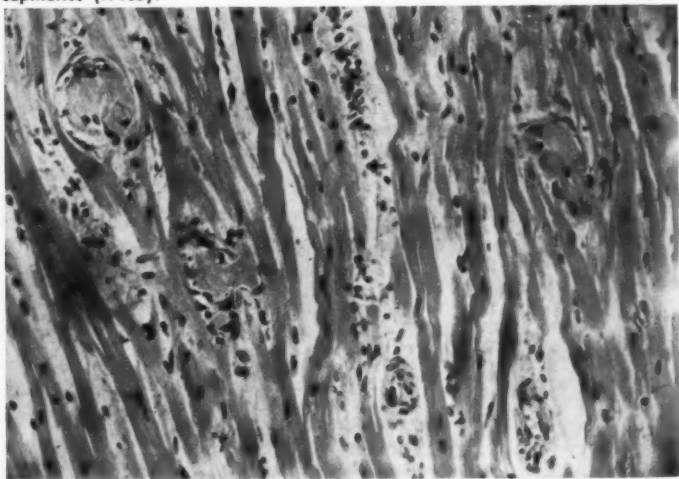
There were longitudinal ulcerations at the lower end of the esophagus. When nasogastric tubes have been passed it is not unusual to find such ulceration.

The pathological findings are best seen microscopically. The first section shows the pituitary gland. In the posterior lobe we see many small blood vessels and capillaries that appear larger and



Pituitary, Pars Posterior (above): Endothelial proliferation and hyaline occlusive thrombi (X 185).

Myocardium (below): Proliferation of endothelium and occlusion of arterioles and capillaries (X 185).



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more prominent than usual. Higher power shows that they are dilated and many of them are occluded by a hyaline appearing acidophilic mass. In many there is no perceptible reaction in the wall of the vessel. These are thought to be the earliest lesions.

Other capillaries are similarly occluded, but we see clear evidence of endothelial hyperplasia about the acidophilic mass. Still other capillaries show very extensive endothelial hyperplasia with infiltration of the acidophilic mass. In a few capillaries there has been disappearance of the acidophilic mass, striking endothelial hyperplasia and apparent recanalization of the vessel. We believe that the lesions described pass from early or very recent lesions to late or almost healed lesions. It is estimated that the late lesions have been present for several weeks — thus accounting for the duration of symptoms in the patient.

It should be noted that little or no evidence of an exudative or cellular inflammatory process is seen in or around the walls of affected blood vessels—a finding very different from that seen when septic emboli occlude vessels.

Lesions of the type described are seen in the anterior lobe of

the pituitary, the heart, spleen, liver, pancreas, kidneys, adrenals and brain. In several organs, including the heart and brain, petechial hemorrhages are seen.

Lesions

Quantitatively, the myocardium is the most severely involved. You can see that every high-power field contains more than one lesion. In the myocardium one sees the full range of lesions that I described earlier and in addition more completely healed lesions are visible. Occasional granular, acidophilic myocardial fibers are visible in the vicinity of the lesions. These fibers show necrobiotic changes. A few lymphocytes and plasma cells are scattered between the myocardial fibers.

Very few lesions are found in the liver. These are in the portal spaces. We find no histological evidence of parenchymal changes or evidence of biliary obstruction that would account for the icterus or the alterations in the liver function tests.

None of the characteristic lesions is found in the lungs. The pulmonary capillaries contain vast numbers of megakaryocytes. We are not aware of the significance of this finding. A few megakaryocytes are found

trapped in pulmonary capillaries in many types of cases.

The pathogenesis of this disease—thrombotic thrombocytopenic purpura is not understood. The thrombi appear to be quite structureless. Some have described them as conglutination thrombi—thrombi containing all elements of the blood. Some believe they have identified red cells in the thrombi.

Recent work with fluorescent anti platelet antibodies has given no evidence that there are platelets in the thrombi. On the other hand, the use of fluorescent anti-fibrin antibodies has given strong support to the thesis that the thrombi do contain fibrin. Whether or not some ill-defined hypersensitivity phenomenon is present as a causative factor, cannot be determined at this time.

Pathological

Pathological Diagnosis: Thrombotic thrombocytopenic purpura with generalized systemic involvement.

Are there any questions?

DR. WARREN SEIBERT, *Assistant Resident, Medicine*. Were lesions found in the skin at autopsy?

DR. PARSONS: We did not section the skin at time of autopsy. We had previously seen biopsies

of skeletal muscle, skin and bone marrow as well as marrow smears. No lesions were found. The biopsies were made in an attempt to find histological proof for the diagnosis which was originally made by one of the interns.

Biopsies

DR. JOSEPH, PICCHI, *Clinical Coordinator and Instructor Medical Service*. Dr. Martin McHenry, one of our former interns, suggested the diagnosis of thrombotic thrombocytopenic purpura and it later became clear that this was what the patient had. On the 6th day after admission the muscle, skin and bone marrow were biopsied with the Nordin-Sacker trephine. They did not show the typical picture. The patient was presented at Medical Grand Rounds before the autopsy findings because the case seemed to be so classical of thrombotic thrombocytopenic purpura.

DR. SAMS: The liver and kidney biopsies were not done because of prolonged bleeding.

DR. SEIBERT: Were the adrenals enlarged?

DR. PARSONS: No, they were not. They were normal in size and showed loss of lipid. The pancreas was also normal in size and showed a few occluded vessels. We found no significant

pancreatitis to explain somewhat elevated serum amylase.

DR. MOVITT: Was there ulceration of the large bowel?

DR. PARSONS: There was no ulceration.

DR. PICCHI: To the time of our

review of thrombotic thrombocytopenic purpura in April 1958, there were 131 cases reported in the world literature. Since then we have seen sporadic case reports and reviews in all of the major medical journals.

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NEWS ROUNDS

Intern Makes News

Ambulance Call—An intern in New York City was recently the focus of headline-making events when he reportedly:

- delayed in answering an ambulance call
- used a penknife to amputate the leg of a man pinned by an elevator.
- blasted his hospital for what he termed an inadequate medical bag on the ambulance.

Criticized by his hospital for statements made to reporters, the intern resigned and left the country for England.

Followup—City hospitals were alerted to check ambulance attendants' bags to make sure they were properly equipped.

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is required to relieve the emotional distress
common to every illness,**

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Since 1942 the legal immunity enjoyed by nonprofit hospitals has steadily faded. Today the prevailing legal view is that charities, just as anyone else, should be required to pay for carelessness.

How the Law Views the Voluntary Hospital

Prior to 1942 it was practically impossible for a victim of negligence to win a legal verdict against a charitable hospital in this country.

The majority of American courts held that nonprofit hospitals were immune from *tort liability*. (A tort is any wrongful act not involving a breach of contract for which civil action will lie.)

Thus when an insane patient committed suicide by tearing an insecure grating from a window and jumping out, the hospital was declared not liable for the patient's death. This ruling was made despite the hospital's negligent maintenance of the window grating. The reason: the hospital was a nonprofit institution.

History

The doctrine of charitable immunity arose from the public policy of fostering donations to institutions and increasing the benefits received by the public from charitable activities.

The major impetus originally behind the doctrine was the fear that the imposition of liability would "do irreparable harm to the charitable hospital. At the time the rule originated, in the middle of the 19th century, not only was there the possibility that a substantial award in a single negligence action might destroy the hospital, but concern was felt that a ruling permitting recovery against the funds of charitable institutions might discourage gen-

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erosity and 'constrain them as a measure of self-protection, to limit their activities.'"¹

Trend

Since the 1940s the trend has been reversed, courts ruling that charitable hospitals are liable, either partially or totally.

"Quite apart from the availability of insurance to protect against possible claims and lawsuits . . . undue hardships or calamities have (not) overtaken them (charitable institutions) in those jurisdictions where immunity is withheld and liability imposed . . .

"In any event, today's hospital is quite different from its predecessor of long ago; it receives wide community support, employs a large number of people and necessarily operates its plant in businesslike fashion . . . The rule of nonliability is out of tune with the life about us, at variance with modern day needs and with concepts of justice and fair dealing."²

Twenty-two jurisdictions now impose total liability on charitable hospitals.³ Twenty-six states recognize the immunity of the charitable hospital, in whole or in part.⁴

Just what is a charitable hospital?

It is defined as a hospital which is not operated for profit, has no capital stock, pays no dividends and is supported largely by public donations. It serves the needy without reward. The fact that those who can pay are required to do so does not change the charitable nature of the institution. The fees received are in turn used to carry on charitable works. Nor must the hospital accept all persons applying to it, to preserve its charitable status.

Theories

Four principal theories have been used by the courts to confer immunity from tort liability on charitable hospitals.

- The theory which gives almost total immunity is the trust fund theory. Charitable funds are treated as a trust not to be diverted to pay tort claims.
- The theory of implied waiver holds that beneficiaries of charity impliedly waive any claim for damages.
- Charitable hospitals are held exempt from the operation of the rule of *respondeat superior* (liability of the master for the wrongful acts of his servant), on the theory that the hospital receives no benefit from the services rendered by its employees.
- Public policy.

Trust fund

Plaintiff was admitted to defendant's hospital as a paying patient. Soon after he was admitted he fell out of bed and sustained injuries. While being treated for those injuries he again fell out of bed and was injured again. Plaintiff alleged that he fell out of bed each time because of defendant's negligence.

The hospital's defense was that it was a charitable institution, not operated for profit, and that the majority of its funds came from charitable gifts.

The case came before the Ohio Supreme Court in 1956. Ohio was at that time a jurisdiction which supported the trust fund theory. The court examined the theory carefully and noted its history.

Dead rule

The trust fund theory was first employed in this country in 1876 when a Massachusetts court revived a rule already dead in England. Back in 1846 Lord Cottenham issued a dictum (a statement not essential to the decision of a case) in a case where a suit had been made against a hospital.

The dictum: "To give damages out of a trust fund would not be to apply to those objects whom the author of the fund had in view, but would be to divert it to

a completely different purpose."

And even in that 1846 case the court pointed out that, while the trust funds could not be diverted, the victim could seek reparation from the pockets of the trustees.

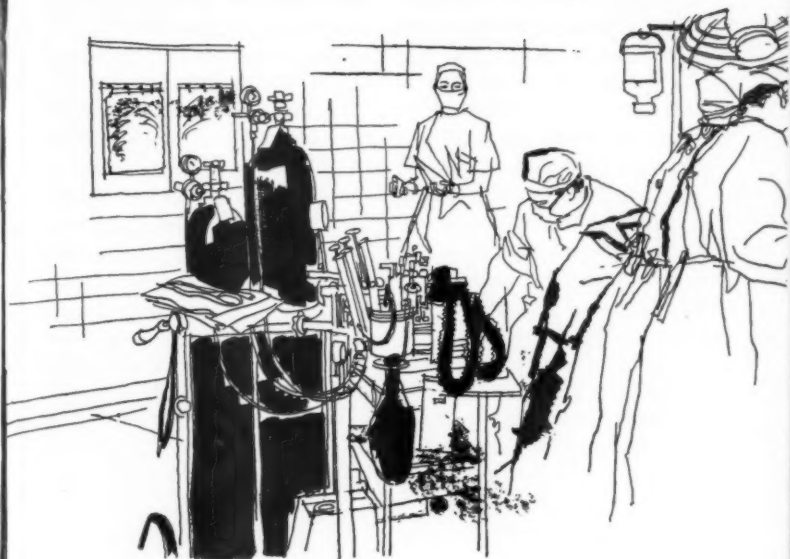
However the theory in the United States grew to one of complete immunity for charitable hospitals. Courts took the view that to permit the diversion of trust funds might result in destroying or substantially impairing the usefulness of charitable institutions; that the donor's intent would be thwarted, and that it was beyond the power of the trustees to divert trust funds to other purposes.

Exceptions

Gradually exceptions began to develop, as is apparent in the history of the theory in Ohio.

In 1911 the original rule of immunity was established. In 1922 the state's supreme court permitted recovery against a non-profit hospital for negligence in failing to use ordinary care in selecting its workers.

In 1930 liability was imposed against a nonprofit hospital in favor of a private nurse injured in an elevator. Said the court: "Charitable institutions, public and private, are on the same basis as other corporations and individuals as to liability . . ."⁵



By 1956 the Ohio court decided that the rule was devoured by its exceptions. The court pointed out the different sources of revenue hospitals have—hospitalization plans, both group and individual—and stressed that a hospital can fully protect its funds through insurance. The court completely rejected the trust fund theory.

A two-year-old girl, a paying patient was taken to the hospital with pneumonia. Her doctor directed that she be given dia-

thermy, and a student nurse was assigned to give the treatments. Through negligence the infant was so severely burned that numerous skin grafts were required.

The court held that the doctrine of implied waiver applied even to a paying patient. The court stated that there is an assumption of risk by a person who seeks and receives the service of a charity. By accepting the benefits of the charity, the patient waives liability, assumes risk.⁶

This case was expressly overruled in 1956 when the court held that a charitable hospital was liable for injuries to a paying patient resulting from negligence of its management or employees.

The court thought it illogical to say a paying patient was a recipient of charity or waived any rights merely by becoming a patient in a charitable hospital.⁷

Jurisdictions which follow the theory of implied waiver permit business callers, visitors and strangers to recover as well as paying patients and employees. In some instances even a true beneficiary of the charity may recover where he can prove the management was negligent in selection or retention of its servants.

Negligence

Charitable hospitals have been exempted from liability for the negligence of its employees on the grounds that a charity does not derive profits from the services of its employees. A business operated for profit, to the contrary, should answer for the negligence of its servant.

Six newborn infants were fed a poisonous solution of boric acid which was negligently prepared instead of dextrose. Five died and one suffered personal injuries. The hospital was not liable for

the negligence on the part of a competent pharmacist.⁸

In a jurisdiction which exempts hospitals from the law of respondeat superior the hospital is liable only for carelessness in selection of its agents or servants, or corporate negligence, as for example failure to provide in the pharmacy proper facilities, safeguards and surroundings.

Doctrine applied

A patient was severely burned during the course of an operation performed at a New York hospital by her own physician, for correction of a fissure of the anus. Prior to the surgeon's appearance she had been made ready for the operation by the hospital anesthetist and two hospital-employed nurses. An inflammable antiseptic was used preparatory to and after administering spinal anesthesia.

The nurse did not examine or change the sheets although they had been instructed to exercise care to insure that none of the fluid dropped on the linen. When the doctor touched a heated electric cautery to the fissure there was "a smell of very hot singed linen" and he doused the area with water. The patient suffered severe burns on her body, and several holes burned through the sheet under her.

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Suit was brought in the courts of New York which had its own doctrine of respondeat superior. This doctrine held that a charitable hospital was not responsible for the negligence of its physicians and nurses in the treatment of patients. Doctors and nurses even though employed by the hospital were to be regarded as independent contractors rather than employees because of the skill they exercised and the lack of control exerted over their work.⁹

Later decisions limited this rule by imposing liability on hospitals for the "administrative" acts of its

employees as distinguished from "medical" acts. Thus a hospital was liable when a nurse placed an improperly capped hot water bottle on a patient's body. This was an administrative act. But where a nurse used the wrong blood in giving a blood transfusion this was a "medical" act and the hospital was not liable.

In the case of the patient who suffered severe lesions, the New York Court of Appeals overruled its past decisions, did away with the administrative-medical distinction and held the liability of hospitals was governed by the

NEWS ROUNDS

Security from Hospital, Surgery Costs

Government Stepping In?—According to U.S. News and World Report, "Major changes, affecting millions, are to be voted in this country's vast system of old-age security in 1960." One of these, which USN&WR gives a 50-50 chance, "-if the administration goes along," is a compulsory program "to provide retired workers, wives and widows with insurance against hospitalization, nursing-home and surgery costs." The Administration, according to USN&WR is ready to admit failure in its efforts to aid private and voluntary insurance programs. The money would come from an increase in social security payments by worker and employer. Organized medicine is vigorously opposed.

same principles of respondeat superior as apply to all other employers.¹⁰

Public policy

All the various theories heretofore discussed have been said to rest finally on public policy. Total immunity has been granted and total liability imposed by the "public policy" of different states.

Public policy is a fluid theory, changing with the times. While the public policy of the 19th century encouraged the establishment of charitable organizations to the

exclusion of all other rights, today's public policy is concerned more with the "reasonable demands and expectations of innocent persons who were injured through the fault of others."¹¹

Some courts have reversed legal trends on the grounds of public policy, while others prefer not to overrule precedent until state public policy is changed by legislation.

However, the legal trend definitely is toward making the charitable hospital totally liable for carelessness and negligence.

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The library in our own day is a victim of tradition.

Although books are no longer dragged behind horses and buried alive, every librarian knows the sudden paralysis that seizes library users just as they cross the threshold. Classification scheme, catalog, shelf list, index—who but a mystic could divine the location of a particular tome?

Our author here offers to cure the paralysis with working knowledge. And unless all medical discovery ceases, the house staffer will be using this knowledge for all his professional career to come.

Your Hospital Medical Library

Saul A. Kuchinsky

Searching the literature for information on a specific topic is one of the chief reasons for being of the medical library. The doctor wants to know a disease more fully, so he seeks articles by other men on the disease. He considers textbooks outdated or not detailed enough in the special

areas that interest him. Since he cannot go into the separate indexes of a thousand journals, he goes to the two great works which interfile the indexes of the thousand journals in one volume. These giant indexes of journal literature are *Quarterly Cumulative Index Medicus*, published by

INDEXES

Index Medicus, begun in its modern series in 1927, is distributed pre-bound twice a year in one author-subject alphabet. *Current List* appears once a month in soft covers, is cumulated by the publishers twice a year and is bound each time it is cumulated. Unfortunately, it has three separate author, subject, "item" listings, but it is indispensable because *Index Medicus* is three years behind schedule.

Since both indexes cover approximately the same journals, it

is unnecessary in the average library to purchase back years of *Current List* if one already has *Index Medicus*. And, since *Current List* is four to ten months behind schedule, the librarian builds a daily card-file index of journal articles of the current six months, at least, to fill the gap.

The index-catalogue of the Surgeon General's Office, a vast work in four series of the holdings of the National Library, is for very large libraries only. Few hospitals have, need or will ask for it.

A.M.A., and *Current List of Medical Literature*, published by the National Library of Medicine.

There are indexes, also, of the literature in special fields such as polio, leukemia, cancer. The hospital library buys as needed.

Journals

Having compiled your bibliography from the indexes, you will need the journals in which the selected articles appear.

First consult the journals' shelf list, an alphabetical listing by title of the library's journal holdings. Eliminating those journals that are missing or at the binders or that the library doesn't have,

(you may request these through inter-library loan) you next proceed to the alphabetical shelving of the bound journals, chronological within each title, and the unbound journals rack, where the paper cover journals stand vertically in their separate cubicles. To take out the necessary bound journals, you date and sign the card inside the back cover. For unbound journals you fill out a printed paper form. You leave both cards and forms with the librarian who makes of them a circulation file which is a record of what is out and a basis for calling in what is overdue. Up to the first few hundred journals¹

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In
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subscribed to by the hospital library are quite basic to all medical collections. The few titles that turn out not worth keeping may be dropped, and new, worthier publications added.

Through gifts and from Medical Library Association Exchange and United States Book Exchange, gaps are filled in for missing years.

Unbound journals go to the binder when a volume has been completed; this is, for 95 percent of them, either once or twice a year. They do not go for binding until at least two issues of journals have been received of the next volume so that readers will have something current to read in the interim. (Binding takes three to five weeks and costs \$2.75—\$3.50 per buckram volume.)

In assaying your own hospital library statistically, figure 75

journal subscriptions and \$800 a year in books per 250 beds, with one-fifth to one-fourth of house staff for seating capacity.

No two libraries are exactly alike in the minor details.

Books

The medical library has few books as compared to journals. They comprise less than 25 percent of the collection. On open shelves, in alphabetical order by subject, books are found by matching the classification symbol at the upper left corner of the appropriate catalog card with the same marking on the outside spine of the shelved book. The Cunningham² and Boston⁸ classification schemes are most popular in hospital libraries, but any system does as well that is logically, simply and continuously carried out as books are received.

About the Author

A graduate of New York University and Western Reserve University Library School, the author has been a school teacher, postal clerk, newspaper reporter and, since 1948, professional librarian. He was circulation librarian at the Union Theological Seminary (Protestant) from 1950 to 1953, organized

or reorganized six Jewish Center libraries in New York from 1951 to 1956. Medical librarian of the Jewish Hospital of Brooklyn from 1953-1959, he is presently librarian at Montefiore Hospital Library, Manhattan. Mr. Kuchinsky has examined 21 hospital medical libraries in New York and some 50 university and public libraries from coast to coast.

Books circulate via book cards just as bound journals do. Reference books don't circulate at all and are so marked. These are atlases, directories, dictionaries, loose-leaf "systems," most multi-volume sets, almost anything expensive, out-of-print, rare or bulky. And, of course, such texts as Cecil or Wintrobe, which a library would have to buy in indefinite copies if it circulated them.

The key to finding books is the book catalog. Although the greatest boon to the book-seeker, it somehow becomes the greatest bogey of the library patron. It is simply an alphabetical file of authors, subjects, titles and cross-references of the books in the library. You read a catalog card alphabetically by the first word of the topmost line on the card, disregarding the three words, "A," "An" and "The." Authors' names appear last name first. "See" cross-references move from terms not used to equivalents that are used. "See also" references lead to books containing some, but not a major part of, the material of the field in which the doctor is searching. And that's all there is to it. You find your book, as we've said, from the class symbol at the top left of the card.

Physical plant

Location is the least understood problem of the special library because it's confused with the public library. Availability at all costs isn't its need. The hospital library in the path of a nursing floor or busy clinic or near an elevator, lobby or busy street is in trouble.

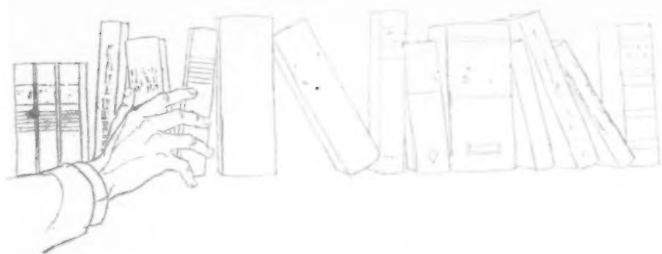
At St. Vincent's in New York City—the author has examined 21 N. Y. hospital libraries in the past 2 years—the beautiful new, breeze-whipped library is on the eleventh floor and free of the hospital's paging system. Hospital for Special Surgery (Manhattan) has a wall-to-wall, carpeted dream-library that looms pent-house-like over the East River. The library is for study.

Seating

Seating arrangements include tables, straight-backed chairs and easy chairs. If there is room for study cubicles outside the main reading room, as at Memorial Cancer (Manhattan), better yet. Linoleum flooring predominates over the more silent carpeting because it is cheaper to buy and maintain. Bird S. Coler (Welfare Island), and Special Surgery report no conflagrations or holes in their carpeting, but the other hospitals play it safe. In either situ-



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ation, smoking is permitted and ash trays are profuse throughout.

Shelving is ceiling high, since space is eventually and eternally a library problem. Magnesium-weight ladders and stools are lighter than wood. At Lebanon Hospital (Bronx), and Jewish Memorial (Manhattan), the library ladder moves along a track at its top, a fine safety provision if there is room and money for it.

Journal racks made by the hospital carpenter shop cost a fraction of bought racks. At Jewish Hospital of Brooklyn, they are built to include 6-10 issues of each journal within one compartment. This allows the reader to browse happily at will and the librarian to take daily inventory in one operation, in contrast to the more typical set-up, in which only single copies have room for vertical display and all other unbound issues are laid flat on racks in a different area.

Lighting is powerful, indirect,

shadowless, ceiling-hung or recessed. Reading anywhere, including titles on topmost shelves, is effortless.

Air-conditioning gives the only assurance that attendance in the library and the quality of study there in the hot summer months will be maintained. Cross-ventilation and fans don't quite match up.

Hours of the library are those that are staffed. Indiscriminate use of the library key results always, when it is left where it can be taken freely, in expensive loss of materials. The key should be kept after hours by a responsible authority — not a porter, not a night watchman—who will open the library only in medical emergency and personally attend the searching until it is through.

Silence is aided, in addition to location, by a separate librarian's office, a storeroom, a workroom for repairs and binding. The librarian's typewriter and tele-



SYMPOSIUM REPORT:

ALTAFUR in antibiotic-resistant staphylococcal infections

ALTAFUR proved superior to any other single agent against staphylococcal infections encountered in the pediatric section of a general hospital. Introduced during an epidemic of severe staphylococcal pneumonia and bronchiolitis in younger children, ALTAFUR was employed in treating a total of 59 infants or juvenile patients, most of whom had upper or lower respiratory tract involvement. Almost all had been given antibiotics without effect; 34 were judged severely or critically ill. Cures were obtained in 54 of these patients after a 3 to 10 day course of ALTAFUR. There was only one failure (results were inconclusive in the remaining four cases). Mixed infections with *Pneumococcus* or *Streptococcus* sp. also responded readily.

ALTAFUR was administered orally in varying dosage: the optimal dose is believed to be about 22 mg./Kg. daily.

Side effects were minimal, being limited to gastric intolerance in a few cases, usually controllable by giving drug with or after meals. Laboratory studies revealed no adverse influence on renal, hepatic or hematopoietic function, nor other signs of toxicity.

Lyssaught, J. N., and Cleaver, W.: Paper presented at the Symposium on Antibacterial Therapy, Michigan and Wayne County Academies of General Practice, Detroit, Sept. 12, 1959 (published Nov., 1959)

bright new star
in the antibacterial firmament

ALTAFURTM

brand of furaltadone

the first nitrofuran effective orally
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- Antimicrobial range encompasses the majority of common infections seen in everyday office practice and in the hospital
- Decisive bactericidal action against staphylococci, streptococci, pneumococci, coliforms
- Sensitivity of staphylococci in vitro (including antibiotic-resistant strains) has approached 100%
- Development of significant bacterial resistance has not been encountered
- Low order of side effects
- Does not destroy normal intestinal flora nor encourage monilial overgrowth (little or no fecal excretion)

Tablets of 50 mg. (pediatric) and 250 mg. (adult)
Average adult dose: 250 mg. four times a day, with food or milk
Pediatric dosage: 22-25 mg./Kg. (10-11.5 mg./lb. body weight daily
in 4 divided doses

CAUTION: The ingestion of alcohol in any form, medicinal or beverage, should be avoided during Altafur therapy.

NITROFURANS—a *unique* class of antimicrobials
EATON LABORATORIES, NORWICH, NEW YORK

phone are a necessary evil that are best kept at a distance. Readers, too, need a small conference room, as at St. Vincent's and Beth Israel (Manhattan), for discussion of professional problems.

Cleaning of the library is carried out regularly for necessary reader comfort and preservation of materials and physical plant. Furniture, ash trays and floors are done daily. Shelves and books, topmost not excepted, windows, blinds, screens and lighting fixtures are on a regular schedule.

Files and records

A card file of bibliographies compiled by the librarian at reader request is an invaluable time saver whenever duplicate requests are made.

A file of reprints of key journal articles is collected by writing to their authors. Special Surgery and St. Clare's (Manhattan) have outstanding reprint files, use of the latter's superseding that of its journals.

A pamphlet file can be organized from the mailings of various medical foundations and associations which specialize in these printings.

Newspaper medical clippings are thumb-tacked daily on the bulletin board at Jewish Hospital of Brooklyn, dated and scotch-

taped by subject into a loose-leaf notebook. More than one doctor has used them for talks to lay groups. The bulletin board bears also a running accession list of book purchases, new book covers, house staff directory and monthly schedules, curricula, notices, etc.

A book-accession notebook may or may not be kept. The librarian's carbon-copy order book is a sufficient substitute, plus the posted list of accessions.

Statistics of attendance, circulation, bibliographies compiled and reference questions answered are handed in to Administration regularly.

Outside help

Inter-library loans from near-by larger libraries are indispensable for research in depth. The National Library of Medicine lends original materials and microfilms of its holdings. Professional searches are made by A.M.A. and the publishers of the loose-leaf "systems" on the market, for their subscribers. They have distributed thousands of "packages" in the form of reprints, pamphlets and lists to libraries on request.

The librarian, if there are no such facilities in the library, uses the microfilm reader of the hos-

The Schering logo is located in the top right corner of the page. It consists of the word "Schering" in a stylized, cursive script font, enclosed within a dark rectangular box.

toses, and drug and serum reactions. POLARAMINE is the *anti*-histaminic which controls allergic reactions by effectively antagonizing the effects of histamine at therapeutic doses lower than those necessary with other available antihistamines.

Histamine is present in those body areas exposed to contact with the external environment: the skin, the upper gastrointestinal tract and the respiratory tree. For this very reason, if your patient develops a cold or illness with allergic complications, his symptoms are particularly troublesome. When an antigen provokes an antibody response, histamine is released, and the familiar symptoms of allergy follow. However, POLARAMINE can effectively control allergic symptoms.

POLARAMINE REPETABS (4 mg. and 6 mg. dosage forms for your patients' convenience) and POLARAMINE Tablets (2 mg.) are of unrivaled effectiveness and safety at doses lower than other antihistamines. Summarizing treatment of a recent group of 100 allergic patients, Babcock and Packard state that POLARAMINE REPETABS were "especially effective in patients who presented sudden, acute allergy symptoms."¹ Remember, too, that POLARAMINE Syrup (yes, it tastes good!) is very helpful in dealing with the young allergic patient or those preferring liquid medication.

Dosage: REPETABS, 6 mg. and 4 mg.—One REPETAB in the morning and one REPETAB in the evening. Tablets, 2 mg.—one t.i.d. or q.i.d.; children under 12, one-half tablet t.i.d. or q.i.d.; infants, one-quarter tablet t.i.d. or q.i.d. Syrup, 2 mg. per 5 cc.—Adults, one teaspoonful t.i.d. or q.i.d.; children under 12, one-half teaspoonful t.i.d. or q.i.d.; infants, one-quarter teaspoonful t.i.d. or q.i.d.

Supply: POLARAMINE REPETABS, 6 mg., bottles of 100 and 1000; 4 mg., bottles of 100 and 1000. Tablets, 2 mg., bottles of 100 and 1000. Syrup, 2 mg. per 5 cc., 16 oz. bottles.

1. Babcock, G., Jr., and Packard, L. A.: Clin. Med. 6:985 (June) 1959.

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POLARAMINE® Malesate, brand of dechlorpheniramine malesate. REPETABS,® Repeat Action Tablets.

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pital record room and the services of the hospital photographer for reproducing a few pages or illustrations. The librarian keeps on file professional translators of foreign medical literature.

Friends of the library groups, or individuals serving the same cause, contribute bound journals, journal subscriptions, books and financial support. At Mount Sinai (Manhattan), the staff has given all of the above plus an air conditioner and a fund from which full physical rehabilitation of the library will soon begin. At Roosevelt Hospital (Manhattan) the widow of the late Dr. Thomas P. Mackie has been donor in his memory of an air-conditioned, 3-room library staffed for the first time by a professional.

Problems, problems

How big should departmental libraries get? Should they exist at all? Should the library duplicate any of their holdings? We say the central library comes first, but a small collection in departments is inevitable; the librarian enters departmental holdings in his catalogs but does not order or process departmental books.

How about integration with the nursing and patient libraries? The United Hospital Fund⁵ looks favorably, if not strongly so, on the

ADMINISTRATION

Who Runs the Library?

The librarian and one or more clerical assistants, day-by-day, the Library Committee, three or four times a year; a hospital administrator specially assigned, and the Medical Board and Board of Trustees, in the long run.

The librarian is a college graduate and library school graduate and is certified⁶ by the Medical Library Association. The committee receives, before it meets, a list of textbook requests channeled through the librarian from medical heads of departments. It also resolves problems as the librarian presents them.

idea, citing economy and space-saving. We say one cute chick can stop three researching M.D.'s dead in their tracks every time. We've never come across an integrated hospital, medical and nursing library yet. Only talk, praise be.

To fine or not to fine, to suspend library privileges or no? Hospital libraries don't fine for overdues, unfortunately, and anything stronger than a librarian's anguished howl is not likely to pass any medical board.

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*Archambault, R.: Canad. M. A. J. 81:28, 1959.

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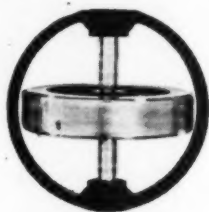
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*unsurpassed for total
corticosteroid benefits*

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Substantiated by published reports of leading clinicians

- effective control
of allergic
and inflammatory
symptoms¹⁻⁸



- minimal disturbance
of the patient's
chemical and psychic
balance^{1, 4, 5, 8-18}

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At the recommended antiallergic and anti-inflammatory dosage levels

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- virtual freedom from potassium depletion
- negligible calcium depletion
- euphoria and depression rare
- no voracious appetite—
no excessive weight gain
- low incidence of peptic ulcer
- low incidence of osteoporosis
with compression fracture

Precautions: With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms.

After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually over a period of as much as several weeks.

Supplied: 1 mg. scored tablets (yellow)
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Vials of 5 cc. (25 mg./cc.).



List of References 1-18 supplied on request.

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the library loses materials, some of it out-of-print, irreplaceable . . . any suggestions?

Also, when to discard old materials and what to do with them? Books two editions or more old are often given to the house staff. Dealers won't accept them as gifts. Most libraries hold on to old journals, some sell them and get respectable sums for new purchases.

Summary

We've described the makings, workings and problems of a hospital library so that house staff will understand the library to make fuller use of it now and in the years of practice ahead. We've tried to show that no hospital with an operating room can be without its own professionally equipped and professionally run Medical Library.

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3. Boston Medical Library: Medical Classification. The Library, Boston, 1944-46.

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5. United Hospitals Fund of N. Y. Committee on Hospital Library Architecture: Planning the Hospital Library. N. Y., 1957.



"Believe me boy, you'll never be better off than you are now as an intern."

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Live Polio Vaccines Get U. S. Test

Studies Underway at Many Centers—Through Grants of more than \$300,000 from the National Foundation, the Dr. Albert B. Sabin-developed live polio virus vaccine is undergoing tests at Western Reserve, Baylor and Yale Medical Centers. The tests of the oral vaccine, expected to continue for periods of 12 to 18 months, relate to dosage, safety, effectiveness and changes in virulence after repeated contacts of three strains of live polio virus. Children involved include newborn in the Western Reserve study directed by Dr. F. R. Robbins, 6-18 month-old infants in the Baylor tests headed by Dr. J. L. Melnick, and from less than a year to 5-year-olds in the Yale study under the direction of Dr. J. R. Paul.

Included in the observations will be children who have had the Salk vaccine as well as children who have not been previously immunized. The Baylor study embraces a community-wide "contact" study through observation of antibody development in 4,400 volunteers associated with the 250 children actually taking the live virus.

First mass testing of the oral vaccine was conducted among more than 12 million Russians who had no contact with the Salk vaccine, and therefore, represented a "pure" sample.

Two other oral vaccines for polio, one developed by Dr. H. R. Cox (for Lederle Laboratories), and the other by Dr. H. Koprowski (Wistar Institute, Phila.) are also undergoing clinical tests here.

No oral vaccine has yet been licensed for general use in the U.S.

Impressive numbers of patients with low back pain and other musculoskeletal conditions, treated with Trancopal, have been freed of symptoms and enabled to return to their usual activities, according to newly published clinical reports.

In a recent study by Lichtman,¹ Trancopal brought excellent to satisfactory muscle relaxation to 817 of 879 patients. The patients in this group suffered from skeletal muscle spasm associated with low back pain (361 cases), stiff neck (128 cases), bursitis (177 cases) and other skeletal muscle disorders (213 cases). Side effects were rare (2 per cent of patients), and it was not necessary to discontinue medication in any of the patients. Mullin and Epifano² found that Trancopal brought good to excellent relief to all of 39 patients with skeletal muscle spasm. (No side effects were noted except slight dryness of the mouth in 1 patient.) This pattern is similar in every new series reported: Ganz,³ DeNyse,⁴ Shanaphy,⁵ and Stough.⁶

Trancopal for dysmenorrhea and tension — Trancopal not only is valuable in treating patients with low back pain and other musculoskeletal disorders, but is also very effective in bringing relief from menstrual cramps and discomfort and in treating patients in anxiety and tension states.

Indications: *Musculoskeletal disorders:* low back pain* (lumbago) / neck pain (torticollis) / bursitis / rheumatoid arthritis / osteoarthritis / disc syndrome / fibrositis / ankle sprain and tennis elbow / myositis / postoperative muscle spasm. *Disorders with psychogenic components:* anxiety and tension states / dysmenorrhea / premenstrual tension / asthma / angina pectoris / alcoholism. **Dosage:** Adults, 100 or 200 mg. orally three or four times daily. Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours. **Now available in two strengths:** Trancopal Caplets®, 100 mg. (peach colored, scored), bottles of 100. New Strength — Trancopal Caplets, 200 mg. (green colored, scored), bottles of 100.

References: 1. Lichtman, A. L.: Scientific Exhibit, meeting of the International College of Surgeons, Miami Beach, Fla., Jan. 4-7, 1959. 2. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 3. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 4. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 5. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 6. Stough, A. R.: *J. Oklahoma M. A.* 52:575, Sept., 1959.

A TRUE "TRANQUILAXANT"
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keeps the patient on the job.



Guest

Editorial

Progressive Fundamentalism

It has been claimed repeatedly that scientific medicine has made more strides in the past fifty years than in the entire history of mankind. Few will question this statement, but it is also evident that the research of scientific medicine has been an enchantress which has lured the novice physician. Not that the science and the art of medicine are incompatible, rather they are complementary; but the desire to use a ruler for precise measurements by mechanical and chemical means is so great that it is often substituted for thoughtful observation of the patient. The norm for "good clinical study" of the average hospital patient seems to consist of pounds of x-ray film, numerous analyses of various body fluids with reports that are sometimes conflicting, and inter-departmental consultations. To a degree these devices have made for more efficient care of the patient. But when they are a substitute for meticulous observation and personal responsibility these devices are mere evidence that the physician has failed to observe and think clearly or that he has attempted to place the heavy responsibility of patient care on the shoulders of others.

D.



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One tablet intravaginally twice daily for 10 days. Course of treatment may be repeated if necessary.

Box of 20 tablets with vaginal applicator.

also available: Triple Sulfa Cream.† Large tube with or without applicator.

*Taleghany, P., and Heltai, A.: *Am. J. Obst. & Gynec.*, in press.



†Trademark



Guest Editorial



JOSEPH PICCHI
Clinical Coordinator
and Instructor
Medical Service
Highland-Alameda
County Hospital

And the patient, what happens to him, this fearful, sick creature, full of worries about his future and apprehensive over what his doctors propose to do? Too often he is secondary to the interesting laboratory findings and somehow one gets the feeling that his doctors would find things much more interesting if only they could inject various tracers, measure various gases or analyze various body fluids. One almost thinks "How much more fun these doctors would have if this patient could only be silenced." Indeed one gets the impression that medicine somehow would be much more fascinating if it were not for patients.

The health of the patient is the object of the art and science of medicine. Thus one must be careful to use the laboratory as a tool for patient care rather than as an end in itself.

It is generally agreed that one can no longer practice medicine efficiently by the mere use of the naked five senses without chemical and mechanical aids. But one must not be bewitched by mere technology. Roentgenograms, electrocardiograms and radioactive circulation times may not give us any evidence for a valvular disease which an increased second pulmonic sound and a faint diastolic apical murmur in the left lateral position will reveal to be an early mitral stenosis. And how often have we seen a patient studied for abdominal pain by various technological means when a simple neurological examination demonstrating Argyll-Robertson pupils and loss of posterior column function as well as a few pertinent historical findings would have revealed the patient's difficulty to have been a gastric

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migraine
musculo-skeletal pain
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fractures
synovitis/bursitis

relief of pain
of all degrees of
severity up to
that which
requires morphine

AND IN

fevers
cough
unproductive cough



NEW YORK, New York

crisis of tabes dorsalis? Who can forget the patient with the polyneuritis, deepening pigmentation, and mental deterioration who had been studied by means of various exotic chemical analyses at a great university center? His real difficulty was shown to be chronic arsenic poisoning and this was uncovered by the intern who saw him a year later and noted the ridging of the nails described in every book on physical diagnosis. The patient may be quite dead by the time the completion of analysis for 17-hydroxycorticoids reveals the presence of acute adrenal failure or the change in antibody titre over a 14 day period prove the presence of a rickettsial disease. Of course, one could cite hundreds of cases in which obscure disease was brought to light only after extensive specialized investigations. These investigations must be used, but they should not be substituted for thoughtful observation.

"Life is short and Art long; the crisis fleeting, experience perilous and decision difficult."¹ It thus behooves the physician not only to rely on mechanical observations but to use his personal observations to the fullest extent. The modern intern knows disease in general and thus can classify diseases according to special causes, symptoms and he can chart the typical course. Now he begins to put this general knowledge to the specific test and it is thus that he needs cases to develop his skill as a physician. These should be varied and in goodly quantity for medicine requires the sort of experience which can be gained only from actual practice. Without the judgment that is born of experience general rules can be misapplied. And that experience is best which is tempered by responsibility and the guidance of those already skilled in the art. A new physician is no longer a medical

1. Hippocrates, "Aphorisms".

student; he should be encouraged to make decisions independently, though he should have the opportunity to discuss his decisions with mature consultants.

It is thus that our large municipal hospitals play an important role in medical education, for they provide that exposure to experience and responsibility for which no amount of scholarship can substitute. It is here that the new doctor meets the "fleeting crisis," and it is here that he must make the difficult decision.

Observations of numerous difficult cases, personal responsibility for the care of such cases—these are the fiery elements which shape the physician. The five senses must be sharpened, the detective instinct fostered, the sense of personal responsibility inculcated and scholarship must not suffer. These are elements of basic training required of all physicians and the pursuit of special skills should be deferred until these basic elements have been mastered.

Listen to what those who yearly have to pass judgment have to say about candidates who fail the practical examination for certification in Internal Medicine. These candidates fail for one of three reasons: "(a) too early concentration in special fields, with the result that many of the common syndromes encountered in the course of examination in a general hospital are seen through a glass darkly; (b) too firm a belief that the clinical pathological or x-ray laboratory will provide the right answer if only the right test or study is at hand, and (c) the inability to make the most of the five senses in the study of the patient."² The criterion for adequacy for certification seems to be firm grounding in basic medical practice. It is thus that emphasis on fundamentals is progressive rather than retrogressive—"Progressive Fundamentalism."

2. Snell, A. M.: Education of an Internist, *Arch. Int. Med.*; 102:923, Nov. '58.



HIGHLAND-ALAMEDA
COUNTY HOSPITAL

Clyde Sunderland-Oakland

ALAMEDA COUNTY MEDICAL INSTITUTIONS

Highland - Alameda County Hospital located in Oakland, California, is one of three Medical Institutions operated by Alameda County for the care of the indigent ill and injured of the County. The other two are Fairmont Hospital, located in San Leandro, and Arroyo del Valle Sanatorium located about five miles south of the city of Livermore. In addition, the county operates for outpatient departments, one each at Highland and Fairmont Hospitals and in the cities of Berkeley and Alameda, as well as two emergency hos-

pitals, one at Highland and one at Fairmont.

Location

Alameda County is situated on the east side of San Francisco Bay directly across from San Francisco. The county is some 800 square miles in area and has a population of 900,000, the principal cities being Oakland, Berkeley and Alameda. The county enjoys an ideal climate, the summer temperature rarely exceeding 80° and the winter temperature never below 35°.

Fairmont Hospital, the first of

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the County Medical Institutions, was founded in the year 1864 and for many years remained the only hospital serving the indigent ill of the county. Fairmont's plant is one of the most modern to be found anywhere, having been almost completely rebuilt since 1948.

Arroyo del Valle Sanatorium was built and opened in 1917 to provide care for childhood and adult tuberculosis.

Highland Hospital, the acute general hospital in the county system, was opened in September 1926 at which time Fairmont Hospital became the chronic, convalescent and rehabilitative unit in the county system. The bed capacity at Highland Hospital is 485 and 48 bassinets, at Fairmont 790 and at Arroyo del Valle 270, for a total of 1545 beds. Only the Highland and Fairmont units are used for resident and intern training purposes.

Alameda County, governed by an elected board of five supervisors, has an appointed county Institutions Commission consisting of 15 members (seven doctors and eight businessmen). The Commission acts in an advisory capacity to the board, as well as to the medical director and administrator of County Medical Institutions.

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Chronic,
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and Rehabilitative
Unit.



ALAMEDA COUNTY MEDICAL INSTITUTIONS SERVICES & STAFF

SERVICE	CHIEF	RESIDENT	SR. ASST. RESIDENT	ASSISTANT RESIDENT	INTERN
Medicine*	Kenelm W. Benson				
Male		1		2	2
Female		1		1	2
Surgery	Edwin M. Taylor				
Male		1	1		2
Female		1	1		2
Emergency*	Walter L. Byers				
Day		1	1	2	4
Night				1	2
Obstetrics	George F. Calvin	1	1	1	2
Gynecology	George F. Calvin	1		1	1
Anesthesiology	Charles Gallup	2		2	1
Comm. Diseases	Leon Lewis			1	1
Psychiatry	Wm. M. McGaughey				1
Ophthalmology	Millard E. Gump	1		1	
Orthopedics*	Douglas D. Dickson	2	1	3	1
Pediatrics	Melvin H. Schwartz	1	1	1	2
Plastic Surg. }	Henry S. Patton				
& ENT }	W. E. Wiesinger			1	
Thoracic Surg.	David J. Dugan	1		1	1
Urology	Harold Kay	1		1	1
Pathology	Robert J. Parsons	1	1	1	1
Radiology	Herman H. Jensen	2	1	1	
Admitting				1	1
Medical Clinic				1	
Oral Surgery	James Hechtman, D.D.S.	1		1	1
Pulmonary Dis.*	William Leftwich				
At Fairmont Hospital		2		2	7
Physical Med. & Rehabilitation	Gerald G. Hirschberg				
Polio Respiratory & Rehab.	Leon Lewis				

* Services common to both Highland and Fairmont Hospitals are administered by the one chief of service.

The attending staff of Alameda County Medical Institutions is composed of 430 members of the Alameda-Contra Costa Medical Association, who give freely of their time and talents on a voluntary basis.

Membership on the staff is through written application, ap-

proved by the chief of the service for which application is made. Appointment, by the Institutions Commission upon recommendation of the medical director, is for one year only and is renewed annually.

Chiefs and associate chiefs of service must be certified by their

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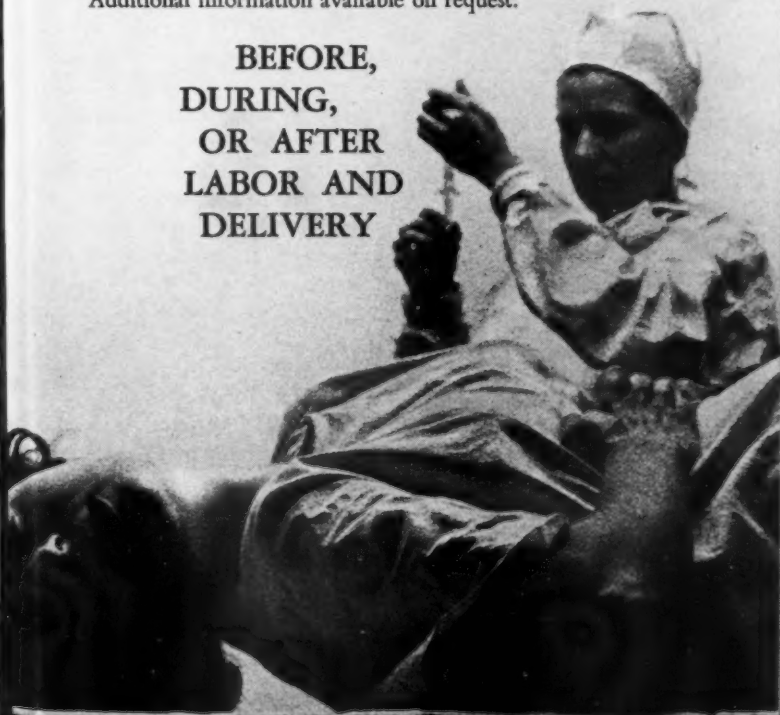
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DURING,
OR AFTER
LABOR AND
DELIVERY**



respective specialty boards; appointments are approved by the staff executive committee before going to the medical director and the Institutions Commission.

The chiefs of the departments of pathology, radiology and anesthesiology are full-time paid members of the staff, whereas, the others are strictly on a voluntary basis. The chief of the emergency surgery division is also a full-time, Board approved surgeon on salary, with two Board approved associates who are on call as needed. In addition, half-time paid clinical coordinators and instructors function in the departments of general surgery and pediatrics at Highland and in general medicine at Highland and Fairmont Hospitals.

Training approvals

The Alameda County Medical Institutions are accredited by the Joint Commission on Accreditation of Hospitals and are approved for thirty-four rotating internships by the Council on Medical Education and Hospitals of the American Medical Association. The Council, together with the respective specialty boards, has granted full approval for residency training in general medicine, general surgery, obstetrics and gynecology, pediatrics, pa-

thology, radiology, orthopedics, urology, ophthalmology, anesthesiology, thoracic and cardiovascular surgery, and physical medicine and rehabilitation.

The American Dental Association and the American Board of Oral Surgery have granted approval for the internship and two years of residency training in oral surgery and dental diagnosis. All Interns are appointed under the National Intern Matching Program.

Other programs

In addition to the resident and intern programs, Highland Hospital has a fully accredited school of nursing which offers two types of curricula, a three-year program leading to a diploma in nursing and a collegiate five-year course given in conjunction with Mills College, leading to a diploma from Highland School of Nursing and a Bachelor of Science degree from the College. Highland Hospital is also approved by the American Dietetic Association for the training of 12 dietetic interns each year. Fairmont Hospital, in conjunction with the Hayward Public School System, conducts a twelve-month course which prepares the students for the State of California Licensed Vocational Nurse examination.



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TAMPAX

SO MUCH A PART OF HER ACTIVE LIFE



Assistant resident in outpatient clinic has opportunity to learn care of ambulatory patients.

Since 1950 Highland Hospital has housed the Institute for Metabolic Research. Under the direction of Laurance W. Kinsell, M.D., the Institute develops controlled investigative procedures in patients with endocrine and metabolic disease, and offers stimulation and supervision of investigation by members of the house staff.

Several fellowships in the Institute are available for the purpose of providing training in the clinical and investigative aspects

of endocrine and metabolic disease. One year of such training may be credited toward certification by the American Board of Internal Medicine or the American Board of Pediatrics. The Institute is supported partly by the county and in part from outside sources. Four beds in a separate 7500 square foot area of the Hospital is given over exclusively to the Institute's activities.

The department of physical medicine and rehabilitation carries on its activities at Fairmont Hospital in conjunction with a regional poliomyelitis and rehabilitation center supported by the National Foundation and operated in affiliation with the Stanford University of School of Medicine.


The National Foundation supplies all respiratory and most technical equipment used on the poliomyelitis service; there are also research grants supporting special investigation at the biochemical and physiological research laboratory of the center.

A recent allocation of Federal funds through the Wolverton Act has aided plans for a 50 bed separate unit with equipment and facilities which will better enable Fairmont Hospital to carry out a presently existing intensive rehabilitation program on patients

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anxiety pushing it up?



SERPASIL® makes it go down!

(reserpine ciba)

FAIRMONT HOSPITAL CONFERENCE SCHEDULE

Monday	Journal Club
Monday	Chest Problem Conference
Tuesday	Rehabilitation Conference
Wednesday	EKG Conference
Wednesday	Internal Medicine Conference — Luncheon
Thursday	Meeting with Visiting Orthopedic Staff & Luncheon
1st & 3rd Tuesday	CPC
1st & 3rd Thursday	Pathology Conference
1st & 3rd Friday	Psychiatric Conference
2nd & 4th Thursday	Medical X-ray Conference

who are particularly good candidates for such procedures. This unit, to cost in excess of \$1 million, will be completed within the next 30 months.

Library

As a result of an agreement made many years ago between the County and the Alameda-Contra Costa Medical Association, Highland Hospital houses and staffs the association library. Located on the second floor of the new, \$2 million outpatient and emergency department which was opened two years ago, the library consists of more than 16,000 volumes and some 300 monthly periodicals.


The Library, presided over by a full-time librarian and an assistant, is available to members of the house staff at the regular hours as well as evenings and over weekends.

In the same building is located

a 12 treatment table, 21 bed emergency hospital, and a modern outpatient department. Adjacent to and connecting with the new building is a 746 seat auditorium for lectures, demonstrations, staff meetings and various symposia which are held throughout the year. The county medical association uses the auditorium for its monthly meetings to which members of the house staff are invited.

Recreation

Public tennis courts and golf courses are easily accessible in the county area. Ping-pong, television and card games can be enjoyed in the house staff quarters. San Francisco with its cosmopolitan reputation and atmosphere offers many cultural advantages in the symphony, the opera and the theater. The close proximity of Berkeley with the huge University of California



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if your
patient
is a
lightning
snatcher

he needn't be grounded for long,
once you prescribe

PARAFON

(PARAFLEX® + TYLENOL®)

for muscle relaxation plus analgesia

Prescribe PARAFON in low back pain—sprains—strains—
rheumatic pains

Each PARAFON tablet contains:

PARAFLEX® Chlorzoxazone† 125 mg.

The low-dosage skeletal muscle relaxant

TYLENOL® Acetaminophen 300 mg

The superior analgesic in musculoskeletal pain

Dosage: Two tablets t.i.d. or q.i.d.

Supplied: Tablets, scored, pink, bottles of 50.

and in arthritis

PARAFON® with Prednisolone

Each PARAFON WITH PREDNISOLONE tablet contains: PARAFLEX®
Chlorzoxazone† 125 mg., TYLENOL® Acetaminophen 300 mg.
and prednisolone 1.0 mg.

Dosage: One or two tablets t.i.d. or q.i.d.

Supplied: Tablets, scored, buff colored, bottles of 56.

Precautions: The precautions and contraindications that apply
to all steroids should be kept in mind when prescribing
PARAFON WITH PREDNISOLONE.

†electrical lineman

†U. S. Patent Pending

McNEIL

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provides intercollegiate spectator sports of a wide variety. Skiing devotees have unexcelled facilities within a four to four and one-half hour drive by automobile.

Each year an active Wives Club of the house staff arranges several parties, particularly at

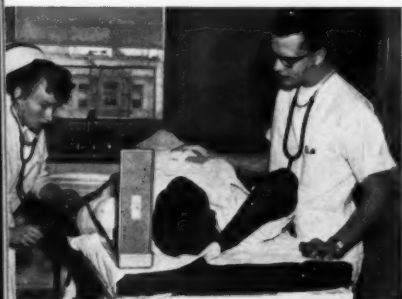
Hallowe'en, Christmas and in the spring. The annual house staff-visiting staff barbecue, held as a get-acquainted session at Fairmont Hospital in September, is a popular event as is the graduation banquet held the last week in June.

Affiliations

Private patient care for house staff training is provided through training affiliations with two Oakland hospitals in the areas of General Surgery, Thoracic and Cardiovascular Surgery, and Obstetrics and Gynecology. The two hospitals are Peralta with 214 beds and Samuel Merritt with 228 beds.

A cardiac catheterization and pulmonary function center is maintained at the latter hospital and thus provides training that the Alameda County Medical Institutions cannot supply. Rotation schedules for residents on various services are in effect at these hospitals. Also a reciprocal exchange on the assistant residency level in internal medicine exists with the Oakland Veterans Administration Hospital.

The Institutions have an affiliation with the Stanford University School of Medicine for children's orthopedics, as well as for the joint operation of the poliomye-



Proper emergency care is an important part of the intern's training.

House staff rounds with Kenelm W. Benson, MD., chief of medicine and Joseph Picchi, M.D., clinical coordinator.



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HIGHLAND-ALAMEDA COUNTY HOSPITAL CONFERENCE SCHEDULE

MONDAY

Obstetrics & Gynecology Luncheon
Pediatric Rounds
Surgery Grand Rounds
Tumor Board
Orthopedic Seminar
Pre-Operative Conference
X-Ray Conference
Hematology Conference

TUESDAY

Pediatric Rounds
Chest Conference
Obstetrics Seminar
Anesthesia Dinner (3rd)
Pre-Operative Conference
Medical X-ray Conference
Dermatology Ward Rounds

WEDNESDAY

Alcoholic Rehabilitation Case Conference
Anesthesia Lecture (Basic Science & Clinical)
Medical-Surgery Luncheon (3rd)
Orthopedic Rounds
Urology Conference
Pre-Operative Conference
Chief's Rounds — Medicine
Metabolic Conference
Neurology Rounds
Medical Psychosomatic Conference (1st)

THURSDAY

Oral Surgery Luncheon (2nd)
X-Ray Conference
Pediatric Rounds
Psychosomatic Conference
Cardiac Rounds
Dermatology Dinner (4th)
Urology X-Ray Conference
Pre-Operative Conference
Pediatric-Psychiatry Conference
Chief's Rounds — Medicine

FRIDAY

Anesthesia Seminar
Pediatric Rounds
Psychiatry Luncheon (2nd)
Medical Grand Rounds
Pre-Operative Conference
C.P.C. (1st & 3rd)
Medical Journal Club (2nd & 4th)

SATURDAY

Medical Death Rounds
Orthopedic Rounds
Medical Chief Resident's Rounds
Gynecology-Pathology Conference

AT INTERVALS

Surgical-Pathology Conference
G.U.-Pathology Conference
Orthopedic-Pathology Conference



Interns' Quarters, Fairmont Hospital Unit, Alameda County Medical Institutions.

litis respiratory and rehabilitation center mentioned previously.

In addition, there is an affiliation with the Donner Laboratory of Medical Physics of the University of California for the joint operation of the Isotope Laboratory at Highland Hospital. This Laboratory is housed in well-appointed quarters in the new building, and is supervised on a better than half-time basis by a Board approved internist with extensive training in medical physics who is also on the staff of the Donner Laboratory. The full-time services of an isotope technician are available.

Additional university affiliations are not sought as the large number and diversity of pathological conditions represented in patient admissions each year to

the Institutions exceed the teaching material available at both the area medical schools.

Quarters

In June of each year the executive housekeeper has a list of available living accommodations in the community and will provide every assistance in finding suitable housing for members of the house staff. Interns and residents list the accommodations they have been occupying with the housekeeping office; members of the Wives Club are of great assistance to incoming appointees.

Resident and intern quarters are in keeping with the general physical excellence of the hospital plants and have been the basis for many compliments from house staff.

*established starting point
for individualized management
of cow's milk sensitivity*

MULL-SOY[®]

LIQUID / POWDERED

Since food allergy creates clinical problems requiring individualized management, the disadvantages of a "fixed" formula are apparent. MULL-SOY, however, provides all the management flexibility of evaporated milk, and may be used in the same way.

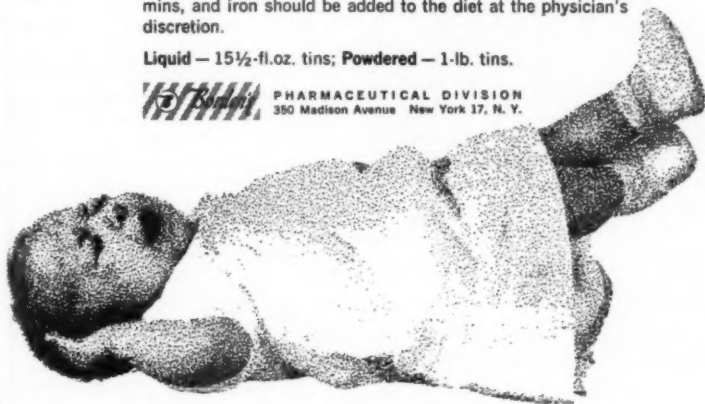
Type and quantity of carbohydrate — and degree of dilution — can be adjusted to the needs of each case. Yet MULL-SOY assures well tolerated protein for good growth, a fat content high in linoleic and the other important unsaturated fatty acids, and dependable relief from milk-allergy manifestations such as eczema, asthma, persistent rhinitis, hyperirritability, colic, diarrhea, vomiting (pylorospasm), and nasal stuffiness.

Other essential nutrients such as vitamins A, D, C, the B vitamins, and iron should be added to the diet at the physician's discretion.

Liquid — 15½-fl.oz. tins; **Powdered** — 1-lb. tins.



PHARMACEUTICAL DIVISION
350 Madison Avenue New York 17, N. Y.





Physician-nurse working area in outpatient department. Patient enters treatment cubicle directly from dressing room, does not traverse the physician-nurse area.

The resident's lounge and snack kitchen.



Interns and residents are required to provide their own uniforms which are laundered free of charge. House staff on "full maintenance," have all personal laundry done without charge.

Health care is provided for all members of the house staff, and under certain circumstances

ANNUAL STIPENDS

Interns	\$1920
1st Year Residents	2400
2nd Year Residents	2916
3rd Year Residents	3060
4th Year Residents	3216
5th Year Residents	3372
6th Year Residents	3540

A deduction of \$45 a month is made from the monthly stipend of each intern or resident who chooses to live in the Institution. Interns are required to live in the hospitals or in the immediate vicinity so they are promptly available. Should they choose to live out, the deduction still is made and they are paid no living-out allowance. Should the resident choose to live outside, the deduction is not made except for \$10 a month to cover the one meal he usually eats in the hospital each day.

would be available to the wife and children of the resident or intern. Should the individual wish to enroll in Blue Cross, the county will pay one-half the monthly premium.

No vacation is granted interns inasmuch as they are part of an intensive and closely integrated



which antibiotic has the plus?

*Today you have a variety of useful antibiotics at your command.
Which one should you choose?*

Mysteclin-V — specific action plus added protection. Mysteclin-V is a combination of tetracycline phosphate complex — one of the world's most widely prescribed broad spectrum antibiotics — and Mycostatin, the first well-tolerated antifungal antibiotic. Together, in Mysteclin-V, these two components provide specific, effective antibiotic action plus added protection against fungal superinfections.¹⁻³

When should Mysteclin-V be prescribed? Accumulated clinical experience clearly indicates that fungal superinfections are on the rise, particularly when broad spectrum antibiotics must be administered in high dosage or for extended periods, in the debilitated and diabetics, during pregnancy, and when corticosteroids are used concurrently. Under such conditions, more than a "broad spectrum" antibiotic is required. Mysteclin-V provides the answer.

Supplied: Capsules (250 mg./250,000 u.); Half-strength Capsules (125 mg./125,000 u.); Suspension (125 mg./125,000 u. per 5 cc.); Pediatric Drops (100 mg./100,000 u. per cc.).

References: 1. Cronk, G. A.; Naumann, D. E., and Casson, K.: *Antibiotics Annual 1957-1958*, New York, Medical Encyclopedia, Inc., 1958, p. 397. 2. Childs, A. J.: *Brit. M. J.* 1:660 (Mar. 24) 1956. 3. Newcomer, V. D.; Wright, E. T., and Sternberg, T. R.: *Antibiotics Annual 1954-1955*, New York, Medical Encyclopedia, Inc., 1955, p. 686.

[®]"MYSTECLIN", [®]"SUNMYCIN", AND [®]"MYCOSTATIN" ARE SQUIBB TRADEMARKS.

Mysteclin-V

SQUIBB



**Squibb Quality —
the Priceless
Ingredient**

SQUIBB TETRACYCLINE PHOSPHATE COMPLEX (SUNMYCIN) AND MYSTATIN (MYCOSTATIN)

rotating program designed to occupy 52 weeks of the year. However, interns have one day off each week, and with the exception of a few services, have every other weekend off.

Members of the house staff have malpractice insurance coverage through a blanket policy carried by the county for all full-time paid employees of the Institutions.

Interns are not required to be licensed in the State of California, but all residents must have a valid license to practice medicine in California at the time they go on the service, or must be registered with the State Board of Medical Examiners to take the first available examination after July 1st.

The administration assists wives of residents and interns to find part or full-time employment, either with the county or elsewhere. There is always a de-

mand for graduate nurses and clinical laboratory personnel.

As far as possible the intern and resident staffs are self-disciplining. A committee of five interns, appointed by their own colleagues, meets monthly with the administration for discussion and clarification of points which may be at issue or on which there may be misunderstanding. This is a luncheon meeting. A similar meeting is held monthly with all members of the resident staff, with the added attendance of all full-time salaried heads of clinical departments. These meetings have proved to be worthwhile in maintaining high staff morale and understanding.

Requests for additional information should be addressed to: *Medical Director, Alameda County Medical Institutions, 2701 14th Avenue, Oakland 6, California.*

Give

The

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Way



specify Bufferin® and avoid salicylate intolerance

Gastric distress due to aspirin used alone is being reported with increasing frequency.¹⁻⁷

BUFFERIN is superior to plain aspirin in that it avoids gastric intolerance; it is "... the drug of choice where prolonged, high salicylate levels are indicated."⁸

"... is 4 to 5 times better tolerated than ordinary aspirin."⁸

Swift-acting BUFFERIN is detectable in the plasma 60 seconds after oral ingestion,⁹ its absorption being expedited by the presence of antacid.¹⁰

1. Muir, A., and Cossar, I.A.: *Brit. M.J.* 2:7-12 (July 2) 1955.
2. Waterson, A. P.: *Brit. M.J.* 2:1531 (Dec. 24) 1955.
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9. Harrison, J. W. E.; Packman, E. W., and Abbott, D. D.: *J. Am. Pharm. Assn. (Scient. Ed.)* 48:50-56 (Jan.) 1959.
10. Paul, W. D.; Dryer, R. L., and Routh, J. L.: *J. Am. Pharm. Assn. (Scient. Ed.)* 39:21 (Jan.) 1950.

FOR A COMPLIMENTARY SUPPLY OF BUFFERIN WRITE:
BRISTOL-MYERS COMPANY, DEPT. BU-13, 630 FIFTH AVENUE, NEW YORK 20, NEW YORK

A GUIDE for our readers

The conventions of the presentation of advertising material on pharmaceuticals are related to certain ethical and practical considerations. This guide should be of help to all our readers in an understanding of the advertising material contained herein. Unless it is stated to the contrary:

All illustrations of physicians and patients are dramatizations utilizing models and not specific physicians or actual patients. The ethical and other considerations for this are obvious.

Illustrative material such as dummy prescription blanks, hospital charts, calling cards, memos, etc., are presented as dramatizations.

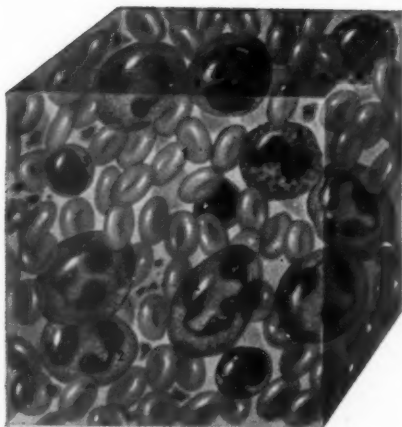
Composite case histories, drawings and/or photomicrographs are often presented to convey typical clinical indications but unless stated to the contrary are constructed as illustrative cases or situations.

Physical limitations of space in journal advertising make the presentation of all relevant data impractical; therefore, it is suggested that for suitable background on dosage indications and contraindications the standard package insert or more extensive background data be consulted.

The acceptance of material for advertising is based upon several criteria; for example, in respect to safety, all new drugs are required to correspond with the accepted Food and Drug application.

It is suggested that any differences of opinion of individual physicians with any advertisements be called to the attention of the editor, with a duplicate copy of the letter to the pharmaceutical house whose advertisement is the subject of the letter.

THE PUBLISHERS



The standard by which the effectiveness
of other iron therapy **MUST** be measured

MOL-IRON®

a specially processed, co-precipitated
complex of *molybdenized* iron offering
all these important advantages:

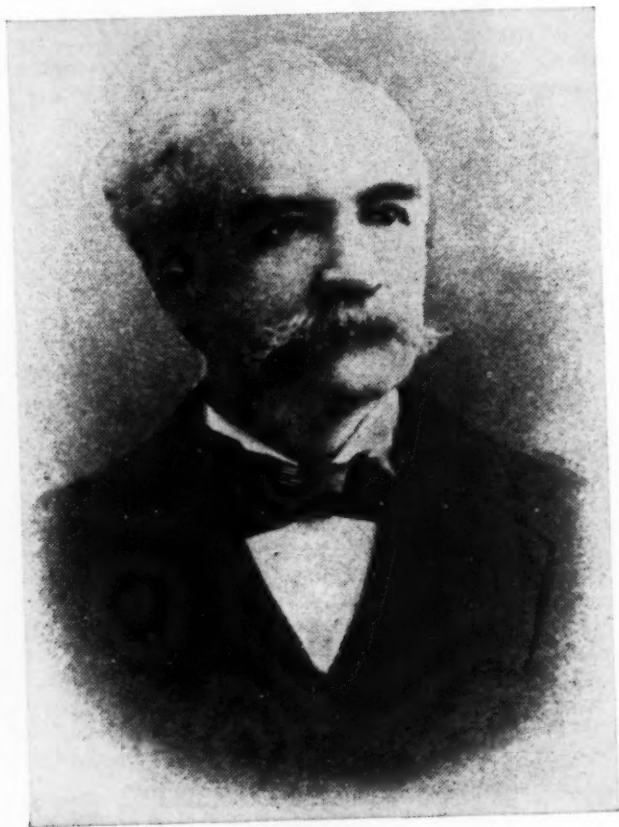
● **MORE** hemoglobin with ● **LESS** medication
in a ● **SHORTER** period of time ● **GREATER**
patient tolerance. ● and . . . costs no more than
ordinary iron preparations.

There is a MOL-IRON product for all of your
patient needs, as listed on pp. 878 to 880 in your
1960 Physicians Desk Reference.



1 Erythrocytes 2 Polymorphonuclear Neutrophile
3 Lymphocyte 4 Monocyte 5 Eosinophile 6 Basophile
White Laboratories, Inc., Kenilworth, New Jersey

MEN WHO MADE THE MEDICINE



JOHN CARNRICK

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REED & CARNRICK: *A Century of Pharmacy*

Founded in 1860 by a young New York chemist, Reed & Carnrick is one of the oldest U.S. pharmaceutical houses. It pioneered in glandular specialties and, through the sale of products to other companies, influenced the development of the industry.

The history of Reed & Carnrick can be measured in terms of two long-lasting managements, and a third, but recently begun. The company's founder and first president, a young New York chemist named John Carnrick, headed the firm for upwards of forty years. Then came more than a half-century of control by the Sartorius family of New York, from the final years of John Carnrick's leadership until 1952. In that year, the company's third and current management took over.

Present glimpses of Reed &

Carnrick's early years tend to be more tantalizing than revealing, because of the failure to preserve corporate records. In that period the company moved several times, with each move unfortunately also bringing a cleanout of company files; for in those blessed days before the income tax there were fewer compelling reasons than now for making and keeping detailed records.

Thus, any Reed & Carnrick history must lean heavily on later accounts of the early days, and even more heavily on the recollections of two people whose com-



in peptic ulcer... both are basic

ALUDROX provides rapid, extended relief of pain in peptic ulcer. Its physiological neutralization is in the range of pH 3 to 5—pepsin is inactivated.

The time-proved combination (4:1) of reactive alumina gel and milk of magnesia in ALUDROX relieves pain, accomplishes healing with no fear of gastrin stimulation, induced constipation or complication of existing constipation.

Wyeth Laboratories Philadelphia 1, Pa.

TABLETS SUSPENSION

ALUDROX®

Aluminum Hydroxide with Magnesium Hydroxide, Wyeth

Also available: ALUDROX® SA (Aluminum Hydroxide with Magnesium Hydroxide, Ambutonium Bromide and Butabarbital, Wyeth); Suspension and Tablets.



A Century
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pany connections date back to the turn of the century. One of these, Miss Maude Hanna, watched from her bedroom window the beginning of Reed & Carnrick's first Jersey City plant; went to work in the newly completed plant in 1899 at age 15; rose to the position of supervisor over the company's female employees; and eventually served Reed & Carnrick for an uninterrupted span of 53 years. The other, Herman Sartorius, was company treasurer for some 40 years during the Sartorius family era.

Glandular specialties

Such glimpses as these sources afford of Reed & Carnrick's early days indicated clearly that the company was decades ahead of its time in its therapeutic concepts. For example, it specialized in glandular products at a date when men like Claude Bernard, the great French pioneer investigator of the glandular field, were getting their first inkling of the pervasive importance of the human glandular system. Reed & Carnrick's theory of glandular medication, while not without its naive element, was often extremely sound: that an extract or product of an animal gland might stimulate, or serve as replacement for, its human equivalent.

Though John Carnrick is said to have become interested in Claude Bernard's work as far back as 1853, the first Reed & Carnrick glandular product was the result of experiments on pepsin which he began in 1861. He obtained some crude pepsin from a Dr. Corvisant of Paris, purified it, added pancreatin and other glandular extracts, and offered it as a prescription digestive aid under the name of Peptenzyme. The product, now used largely to mask the unpleasant taste of other medicines, is still in the Reed & Carnrick line.

Some of the early tests employed to determine the value of the digestive aid had a distinctly heroic air about them. In one, John Carnrick is said to have hired a number of "mendicants" as his human subjects. Then he "fastened silken cords to pieces of meat of identical measure, weight, and character, which each man swallowed. After the passage of a specified time, the meat was pulled up and weighed, in order to ascertain just how much had been digested. Then the experiments were repeated with the aid of Peptenzyme tablets."

The account does not give the precise results; but they were presumably satisfactory, for Peptenzyme remained the largest sell-



In the 1880's the company won medals for infant foods.

ing single product over much of the company's history.

Sale of products

In 1886 Reed & Carnrick suddenly realized that it was carrying too extensive a group of products, consisting not only of glandular specialties but also of a general line of pharmaceuticals appropriate for a much larger house. Therefore, while retaining its glandular specialties, it sold off the rest of its line of "elixirs, tinctures, pills, tablets, and other appurtenances of the old-time drug house" (to quote a company history of some years later) to a small new Detroit firm named Parke, Davis & Co.

Reed & Carnrick was originally founded as Reed, Carnrick & Andrus, reflecting the fact that John Carnrick had two associates. Reed, described only as a young

New York businessman and amateur physiologist, apparently soon dropped from the company picture and from the pharmaceutical industry as well, leaving so little trace that the few remaining company records differ as to whether his first name was James or David. But John E. Andrus of Yonkers, New York, left a decided mark on the pharmaceutical field and on the larger business world as well.

In 1877, John Andrus parted company with John Carnrick and set up several small pharmaceutical companies, the ultimate survivor of which was the Arlington Chemical Company of Yonkers. Andrus acquired a fortune of many millions from his varied business interests. In his later years he turned to philanthropy and public service, donated an athletic field to his college, Wesle-

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for infant foods, soluble foods and Kumyss tablets.

yan University, and served both as mayor of Yonkers and as U. S. Congressman from the Yonkers district. Some two decades after his death in the early 1930's (at age 92), Arlington was sold by his estate.

Other companies

Another pharmaceutical company also grew to importance on a foundation of Reed & Carnrick products. At about the time that Andrus was starting his new ventures, John Carnrick apparently found himself in a sufficiently tight financial spot to warrant selling off a valuable product. The one he chose was Maltine; and the Maltine Co., which was set up to manufacture and distribute it, became in due course Chilcott Laboratories and eventually an integral part of Warner-Chilcott Laboratories, ethical

drug division of Warner-Lambert Pharmaceutical Company.

Still another pharmaceutical company was a spiritual descendant of Reed & Carnrick, though having no direct corporate connection. In the 1890's George W. Carnrick, a nephew of John Carnrick, worked for the company for a time. Early in the Sartorius era, however, he decided to go into the pharmaceutical business for himself, and in 1899 set up the New York firm of G. W. Carnrick Co. Still very much a family enterprise—its current president is Robert Carnrick—in the 1920's it moved to its present location in Newark, New Jersey.

Among the more interesting Reed & Carnrick ventures, during the John Carnrick regime, was the company's pioneering in baby foods, for whose manufacture it set up a special plant in Orange

County, New York, near the village of Goshen. The *Scientific American* for April 7, 1888, describes in detail the making of Carnrick's Food for Infants, a process which began by mixing pig pancreas extract with slightly heated fresh milk to break down the casein.

The nearby farmers who supplied milk to the plant (which was put in that location because of the extensive dairying in the area) had to submit to rigorous conditions: for example, stables had to be whitewashed at least twice yearly; all pools of stagnant water from which cows might drink had to be fenced in or drained; and "only spring wagons must be used in delivering milk to the works, to prevent churning."

The *Scientific American* article, which noted that Reed & Carnrick products "are used extensively by the medical profession in every civilized country on the globe," also included a most emphatic testimonial from a Professor Stockbridge of the Imperial College of Agriculture, Japan. He wrote that "the Carnrick food is as perfect and efficacious in practice as its composition is correct in theory, and appears to be compounded on thoroughly scientific principles, in this respect differing from most of the other articles

placed in the market for similar uses."

Despite the promise shown by the baby foods (which the *Scientific American* reported as being in such demand that "the manufacturers have been compelled to produce machinery that will turn out about ten times the quantity that was sold a year ago"), John Carnrick's scattering of attention over so many fields seems gradually to have put the company into financial hot water. His search for additional backing led him to the wealthy and prominent Sartorius family of New York; and in the late 1890's the head of that family, Otto Sartorius, acquired complete control of the company through a combination of loans and stock purchases.

Despite the lack of financial success, this venture into the preparation of foods had its rewards, because in the late 1880's, the American Institute of the City of New York (founded 1828), awarded three medals to Reed and Carnrick for its infant foods, Kumyss, and soluble foods. The medals were given because in the opinion of the Institute, these products represented notable technical advances.

However, John Carnrick remained as president until his death shortly after the turn of the



in acute cardiac arrhythmias

VISTARIL®

hydroxyzine pamoate

can restore normal sinus rhythm...sometimes within minutes

The gentle tranquilizing effect of VISTARIL dispels fear and anxiety and rapidly reassures cardiac arrhythmia patients.

In addition, VISTARIL appears to act directly on the myocardium. Normal sinus rhythm is frequently restored and maintained.

Therapeutically, VISTARIL is particularly effective in arrhythmias of sudden onset.

Prophylactically, VISTARIL may decrease or entirely prevent the number of attacks of paroxysmal auricular tachycardia or fibrillation.

Further information is available from the Medical Department on request.

Pfizer Science for the world's well-being™

Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc., Brooklyn 6, New York

century. Miss Maude Hanna, who as a young girl worked for him, recalls him as a man of medium height with quick, alert eyes, kindly in impulse but demanding performance from others no less than from himself. He continued to work even into the early stages of his final illness, and is remembered dictating letters while resting on an office couch. Among the devoted friends whom he left at the company was his former coachman, August Endlekofer, who ran the company department responsible for grinding and vacuum-drying the animal glands received from the abattoirs.

Major changes

The Sartorius regime, which saw a sharp spurt in Reed & Carnrick's growth, began with some major changes. In 1899 the company moved into a new plant on Jersey City's Germania Avenue (changed to Liberty Avenue during World War I). And, equally important, Reed & Carnrick's concentration on ethical drugs was emphasized by its first appointment of an M.D. as company president—a tradition maintained throughout the remainder of the Sartorius era, a period of some fifty years.

The company did not immediately begin to prosper under

the first of its M.D. presidents, Dr. Edwin Leonard, for on occasion Otto Sartorius had to advance money to meet plant payrolls. Otto Sartorius' remedy was to increase the family's effective control by grooming his son, August M. Sartorius, for the Reed & Carnrick presidency. With this end in view August Sartorius majored in chemistry at Brooklyn Polytechnic Institute and was graduate from Yale Medical School, becoming president of Reed & Carnrick in 1915.

Dr. August Sartorius' regime, though unfortunately lasting little more than a decade, was one of ebullient progress for the firm. The number of employees, which had long been around thirty, quickly grew to a hundred; sales increased by a still larger amount; and in 1923, the company moved into larger quarters on Jersey City's Van Wagenen Avenue.

Publication for doctors

This progress was undoubtedly aided by a noteworthy Sartorius innovation, the issuance of one of the earliest regular company publications for doctors only, Reed & Carnrick's *Medical Pocket Quarterly*. Beginning in June, 1920, for the next thirty-one years the *Quarterly* brought U. S. doctors occasional articles on

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such service subjects as how they might tactfully collect overdue bills, or the dangers inherent in free medical clinics, or the many unpaid services which a doctor renders to his community.

But its specialty was feature stories and anecdotes in a lighter vein aimed at the general practitioner. (The *Quarterly* once described Reed & Carnrick as the "glandfather" of glandular therapy.) Its flavor was perhaps best exemplified by a column that ran for many years under the signature of "Dr. G. Rouch, M.D.," a salty old codger continually fretting about a variety of homespun subjects.

The editor and guiding spirit of the *Medical Pocket Quarterly* was a New York City urologist, Dr. H. Sheridan Baketel. As a close friend of Dr. Sartorius, Dr. Baketel gradually began to prepare more and more of Reed & Carnrick's promotion pieces and direct mail advertising—a field in which the company learned early the importance of providing educational material for the physician. Another factor also served to draw Dr. Baketel closer and closer to the company; for Dr. Sartorius was suffering from a serious kidney ailment that had been made worse by a rugged period of front-line service during World War I.

Upon the death of Dr. Sartorius in November, 1926, Dr. Baketel became the third M.D. to assume the Reed & Carnrick presidency, a post which he held until his retirement in 1952.

At one time Dr. Baketel was a lecturer in preventive medicine at the Long Island Hospital Medical School, and was Editor-in-Chief of *Medical Economics* for more than twenty-five years. (Editorial Note: Dr. Baketel had a summer home in New Hampshire and the Editor who met him there before World War II, remembers him as a very interesting and kindly individual.)

New products

Immediately after Dr. Sartorius' death, and as the result of research that had gone on for some two years, Reed & Carnrick introduced three new sex hormone products. During the quarter-century of the Baketel presidency the company continued to broaden its base in glandular medicine, and took vigorous steps to diversify into other therapeutic areas such as dietary supplements, antacids, and feminine hygiene products.

But these product moves were not of sufficient weight to solve the major problem confronting every pharmaceutical company, a

problem that Dr. August Sartorius had foreseen before his death—the urgent need for an adequate research base. The only course open to the company was to set up a research program—which led to the establishment of The Reed & Carnrick Institute for Medical Research.

The company's research activities have yielded many noteworthy products, one of the earliest of which was a new synthetic estrogen.

Since then the company has markedly expanded its research

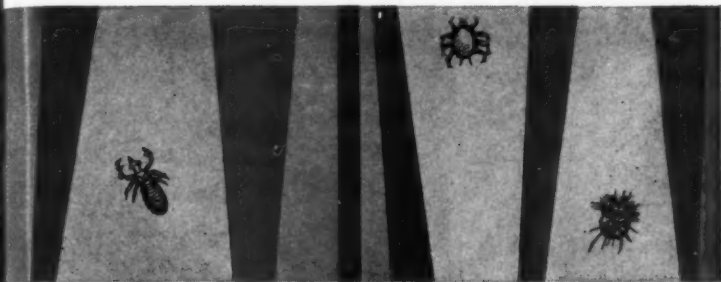
program, and from that research has flowed products designed for varied therapeutic applications.

The most visible sign of Reed & Carnrick's resurgent vitality is the new laboratories in Kenilworth, New Jersey, opened in July, 1959, only a few months short of the company's 100th anniversary. But behind the ample research facilities and the ultra-modern production and handling equipment lies an equally important intangible—the tradition of having for a century served physicians honestly and well.



"Are we going to use this technique on all hypothermia cases?"

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Gardner, J.: J. Pediat. 52:448 (Apr.) 1958.

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QUIET, PLEASE!

YOUR WIFE'S TALKING



Why I Am A Pre-Medical Student

Goldie Gendler

Since I am engaged to marry a medical student, on the evening of December 10, I attended a meeting of, and attempted to join, the University Premedical Society. I was allowed to visit the meeting, but I was refused admittance to the society because the members felt that preparing to be a doctor's wife was not preparing for a medical profession.

Apparently, the members of the Premedical Society share in a general misunderstanding of the role of a doctor's wife in our society.

Many people believe that it is the duty of a doctor's wife to provide a Different Kind of Home Life. She must be prepared to face calmly all the irregularities in their life that her husband's profession will bring, and adjust to all sorts of last minute changes in plans with no strain at all. She must aid him in furthering his career by joining organizations and

*when anxiety
accompanies
somatic
complaints*



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"Outstanding results were obtained in the patients with gastrointestinal symptoms. . . . In depressed patients, there was a notable restoration of energy and drive, without euphoria."

Phillips, F. J., and Shoemaker, D.M.: Treatment of Psychosomatic Disorders in General Practice, Report accompanying Scientific Exhibit at the 12th Clinical Meeting of the American Medical Association, Minneapolis, Minnesota, Dec. 2-5, 1958.

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"becoming known." She must keep up her appearance, so that everyone can see how successful he is, and yet she must never take the spotlight from her brilliant husband.

The members of the Pre-Medical Society would have the woman married to a doctor lose all of her individuality in favor of the typed, all-of-the-same-mold anonymity of a Doctor's Wife.

Status

Actually, the doctor's wife practices medicine right alongside of her husband. That is why she deserves professional status.

I believe that the Premedical Society has made a grave error in denying me membership, for even as a medical student's fiancée I have acquired professional standing and built up a large practice among my acquaintances; marriage can only reinforce my position. Therefore, in order to prove that I have grounds to demand membership in the Pre-medical Society, and in order to clarify the role of a doctor's wife, I should like to describe my practice as a resident physician in the Residence Halls for Women of this university.

Many and varied are the cases in the women's dorms brought to my attention and care every week.

When a patient comes to me, her opening remark invariably is, "You're engaged to a medical student, aren't you?" As soon as I acknowledge my status, she proceeds to describe or display her symptoms, and then waits trustingly and hopefully for my diagnosis and prescription. I have taken a stern and solemn oath, to my medical student, to send all the really sick people who come to me to an M.D. Beyond that there are many cases where common sense, an aspirin, or a dab of iodine are the only remedies needed, and in these cases, I become a general practitioner.

Serious

My first case was a girl who had dark lumps along the side of her foot. She came to me to ask what I thought they might be. I had never seen anything like them before, and so, true to my oath, I told her that they might be serious, and suggested that she see a doctor for treatment. My diagnosis proved correct. An orthopedic surgeon called them benign tumors, and gave the girl a series of x-ray treatments.

Another early case of mine was a girl who had boils on her—who had boils. I thought they were harmless, but since I had been practicing for only a week

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or two I wanted to check my diagnosis. I instructed her to drink lots of water and cut out all sweets, and I suggested that she see a doctor for confirmation. He agreed with me on all counts.

Emergency

The first emergency case I encountered came just after midnight on Tuesday, October 6. One of the girls, walking barefoot in her room, had picked up a splinter in the large toe of her right foot. She hobbled into my room and woke me up by shouting, "Medic! Medic!" Although I had never removed a splinter before, I bathed the toe in warm water to soften the skin, sterilized a needle in a match flame, and efficiently dug out an enormous sliver of wood, at least an eighth of an inch in length. While my patient pronounced the operation painless, I applied merthio-

late and a band-aid, and proceeded to deliver a lecture on the evils of walking barefoot.

Expert

Since that night I have become expert at removing splinters, treating small cuts and bruises, and holding heads. I can rub backs and read a thermometer. I treat hangovers with black coffee and sunburns with vinegar. I apply calamine lotion or Noxzema to pimples and blemishes, along with a warning to stop picking at them. Rest and gargle are the words for colds. Aspirin, Empirin, and Alka-Seltzer I dispense as needed.

A common ailment in a women's residence is a broken heart. My certifications as expert in this field include a textbook called *Love and Marriage*, and the symbol of having successfully completed a marriage course, an

From
The
Author

The author, wife of an intern at the University of Oregon Hospitals and Clinics writes: "Since writing the essay, I have progressed from medical student's fiancée to medical student's wife, to intern's wife, and, most recently, to mother of intern's child. I have found that as my status im-

proved my 'practice' improved accordingly, and though at present I find myself limited to obstetrics and pediatrics ('Are you sure the sun won't hurt my baby?'), the future looks bright. My husband plans to enter the navy shortly. Who knows what opportunities for naval medicine lie ahead for me?"

engagement ring. My method of treating broken hearts includes offering an open mind and ear to hear their troubles, showing them the book, and advising the girls to "look at it from his side." Many are the evenings when a disgruntled pinmate has come into my room at 10:30 with the instruction, "Read me that definition of love again."

Many remedies


The various types of cases that I am called in on require that I stock many kinds of remedies. One shelf of my bookcase is devoted to medical supplies. In addition to the aspirin and Noxzema mentioned above, I have different sized needles (for different sizes of splinters); iodine, Mercurochrome, and Merthiolate (so I can offer my patients a choice); band-aids in three sizes, all waterproof, and in assorted colors; a jar of instant coffee; a bottle of Listerine; salt; a bottle of Absorbine, Jr.; and a styptic pencil. I have a small black bag that I could use to make calls outside my room, but so far all my patients have come to me, and I have not had the opportunity to use it.

Much of the competition among resident physicians in the residence halls arises in the field

of stock and supplies. Girls whose fathers are M.D.'s can offer vitamin pills, cold tablets, and super-potent aspirins, that are available to first-year medical students and their fiancées only by prescription. Although no medical man (or woman) would ever stoop to advertise, the answer to the M.D.'s well-stocked daughter is a few loud, well-chosen remarks on the tremendous progress *modern* medicine has made. The wise, knowing look is all important at this time.

I have one advantage over my competition. My fiancé is still in the process of learning medicine, and I can pick up little bits of knowledge from him. The doctors' daughters, whose sources are not in the process of actual study, do not have the same familiarity with medical terms that I have. They can look at a skin blemish and call it "a bump" or a "pimple." I would look more closely and call it "an infected hair follicle." What they would call a "baokache," I would call a "sprained trapezius or levator muscle." I think it adds a certain flavor of professional dignity.

There are some disadvantages to my practice, especially to one planning a career connected with medicine. For one thing, conditions in the residence halls force



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specialization in women's problems, at a time when I feel that I am far too young to limit myself so. In the second place, emergency calls late at night usually route my roommate, and often the entire corridor, as well as me out of bed. In my poor outraged roommate's midnight reactions to my calls, I can preview my own feelings as a disturbed wife, and the picture is not an encouraging one. The third disadvantage to my practice is that I am not given nearly enough credit for my accomplishments. When I tell a girl that she needs treatment and send her to a doctor, the M.D. who treats her is credited with a cure. I get no credit at all for sending her to the doctor in the first place. The fourth and last disadvantage, and most discouraging, is that I am never paid. I never send state-

ments. I don't try to collect. I couldn't accept a fee if it were offered to me, for fear of being charged with practicing without a license. The discouraging thing is that no one has ever offered.

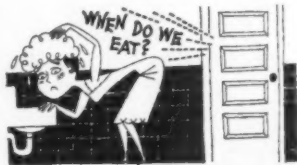
Rewards

On the other hand, the rewards to be gained from a practice like mine are far above money. My reward is the satisfaction and the pleasure that come with sharing my future husband's profession, with helping people, and with preparing for my own chosen profession of doctor's wife. My reward is the opportunity to see and work with some really fascinating people that come to me for help. . . . *Yes my husband is a resident . . . No kidding . . . Really? . . . No kidding . . . Where? . . . How about that. Just a minute, I'll get my bag.*

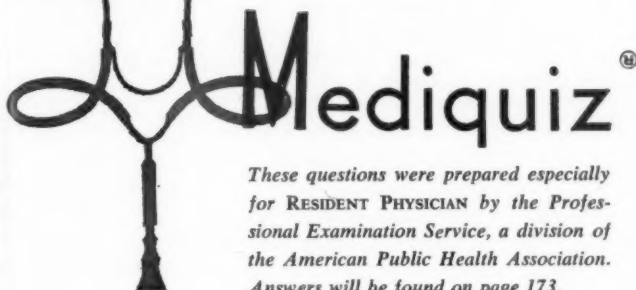
RESIDENT TO SPOUSE (free translation):

HE SAYS: "I'll be home late this evening. Have to dictate some charts and we expect four admissions."

SHE KNOWS: The dictating machine will be out of order and three admissions won't show up. He'll come home earlier than ever before, just as you're shampooing your hair and want to know, "How soon do we eat?"



A **Resident Physician** MONTHLY FEATURE



These questions were prepared especially for RESIDENT PHYSICIAN by the Professional Examination Service, a division of the American Public Health Association. Answers will be found on page 173.

1. Of the following types of keratitis, the only one which is characterized by a tendency to remissions and exacerbations is:

- ☒ A) Rosacea keratitis.
- B) Keratitis sicca.
- C) Neurotrophic keratitis.
- D) Phlyctenular keratoconjunctivitis.
- E) Keratomalacia.

2. In a complete transection of the spinal cord, the only fiber tract which would show ascending degeneration is the:

- ☒ A) Rubrospinal.
- B) Ventral corticospinal.
- C) Vestibulospinal.
- D) Tectospinal.
- E) Spinotectal.

3. Which one of the following diseases is *not* characterized by basal ganglia involvement?

- A) Dystonia musculorum deformans.
- ☒ B) Erb's spastic palsy.
- C) Kernicterus.
- D) Pelizaeus-Merzbacher disease.
- E) Jakob-Creutzfeld disease.

4. In the athetoid type of cerebral palsy which of the following would be the most likely site of the lesion?

- ☒ A) Caudate nucleus.
- B) Cerebral cortex.
- C) Broca's area.
- D) Circle of Willis.
- E) Cerebellum.

The physician answered a call in the middle of the night to treat a 50-year-old female patient who had been vomiting as a result of a biliary colic. She was allergic to morphine and, in previous attacks, had experienced nausea and vomiting with a synthetic narcotic agent. "MUREL" was given in a dosage of 2 cc. I.V. The pain subsided in 10 minutes, and within 20 minutes the patient was asleep and remained comfortable for the rest of the night.

Case history based on Medical Records, Ayerst Laboratories

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SPASM HOWEVER SEVERE

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"MUREL" Injectable No. 405 — 10 mg. Valethamate bromide per cc. 1 to 2 cc. I.V. pr I.M. every 4 to 6 hours up to a maximum of 60 mg. in 24 hour period. Maintenance: Orally.

The higher dosages of "MUREL" are recommended in early therapy and in G.U. and biliary tract spasm.

1. Pöschel, U.: *Med. Klin.* **50**:1479 (Sept. 21 1955).
2. Böndt, R.: *Arzneimittel-Forsch.* **5**:711 (Dec. 1, 1955).
3. Rostajski, M.: *Zentralbl. Gynäk.* **78**:1153 (July 21 1956).
4. Holbrook, A. A.: *Am. Pract. & Treat.* **10**:842 (May 1959).



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5. Experiments by Markowitz indicate that following ligation of the hepatic artery in dogs, it is possible to decrease the mortality and incidence of hepatic necrosis by:

A) Frequent large blood transfusions.

B) Parenteral administration of protein hydrolysates.

C) Ligation of the portal vein at the time of the original operation.

~~D)~~ Parenteral administration of antibiotics.

E) Large doses of vitamins and a high protein diet.

6. The only one of the following anemias that is characterized by an elevation of the plasma iron is:

~~A)~~ Pernicious anemia.

B) Chronic hypochromic anemia.

C) Anemia in pregnancy in the third trimester.

D) The simple chronic anemia of infection.

E) Anemia caused by hookworm infestation.

7. If one finds a macrocytic anemia in a patient with congenital hemolytic jaundice the clinical hemolytic jaundice, the clinical which this is usually best correlated is:

Doctor,

when you're ready, remember ...

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A) The presence of coincidental achlorhydria.

B) The size of the spleen.

C) The degree of red cell fragility in hypotonic saline solutions.

D) A positive Coomb's test.

✕ E) The severity of the anemia.

8. A positive histamine test in a patient who has a pheochromocytoma would show:

A) An immediate rise and then a fall in blood pressure.

B) A sustained rise in blood pressure.

C) No change in blood pressure.

VOLUME 2 MEDIQUIZ READY

A second volume of 150 Mediquiz questions, answers and references compiled by the Professional Examination Service, Division of the American Public Health Association is now available in booklet form for \$1 per copy. The supply of booklets is limited. To be certain you get your copy, send your dollar now to: Professional Examination Service, Department 23-B, American Public Health Association, 1790 Broadway, New York City 19, New York. Please specify "Volume 2." (A few copies of Volume 1 are available at \$1 each for those who missed out on this valuable study aid.)

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D) A sustained drop in blood pressure.

~~E~~) An immediate fall and then a rise in blood pressure.

9. The characteristic triad of findings in the infantile variety of toxoplasmosis is:

~~A~~) Internal hydrocephalus, bilateral chorio-retinitis, and intracerebral calcifications.

B) Bilateral optic atrophy, paralysis of scattered muscle groups, and terminal uremia.

C) Congestive heart failure, uremia, and splenomegaly.

D) Areas of osseous rarefaction, exophthalmos, and diabetes insipidus.

E) Uveoparotitis, bilateral eighth nerve deafness, and ascites.

10. Benign exophthalmos in thyrotoxicosis is thought to be related to thyrotoxicosis, but malignant exophthalmos is due to:

~~A~~) Excessive production of pituitary thyrotropic hormone.

B) Iodine deprivation.

C) The inhibition of formation of pituitary thyrotropic hormone.

D) The compensatory increase of thyrotropic hormone because of the decreased level of thyroxine in the blood.

E) An increase in circulating protein-bound iodine.

VIEWBOX DIAGNOSIS

(from page 23)

DERMOID CYST OF RIGHT OVARY

The shape of the dense calcification has the appearance of a tooth. This is associated with an area of radiolucency due to fat in the cyst.

MEDIQUIZ ANSWERS

(from page 169)

1 (A), 2 (E), 3 (B), 4 (A), 5 (D), 6 (A), 7 (E), 8 (E), 9 (A), 10 (A).

WHAT'S THE DOCTOR'S NAME?

(answer from page 174)

JEAN BASIELLAC
(known as FRERE COSME)

RESIDENT RELAXER

puzzle on page 29

GRAF	MASSE	MAHA	
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	CUTE	ARYL	
ANTIBODY	SELLAR		
ROOSEVELT	LAETI		
ROT	MOI	MON	
OSAGE	ARMSTRONG		
WELLER	NEURONES		
	ILOG	SLUB	
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What's the Doctor's Name?



Rodney A. Mannion, M.D.

Born in 1703, this man was descended from a family of surgeons. He received his education at Lyons and later, in Paris, where he was a pupil at the Hotel Dieu.

After becoming a doctor he was appointed personal physician to the Prince Bishop of Bayeaux and continued in this capacity until the death of the prelate. Then, the young man entered the surgical school of St. Cosme where he gradually began to center his attention on lithotomy.

The instrument which he used in performing perineal lithotomy was the "lithotome caché" which was a hollow tube with a concealed blade. This was used to sever the prostate. He took particular care to open the wound widely so the stone was removed without needless trauma. Of the first 330 patients under his knife 316 were deemed successful cases.

His fame as a lithotomist spread. It excited some profes-

sional resentment and an attempt was made by the surgeons of Paris to have the king interdict his activities. Failing in this, his rival, Monsieur LeCat published material suggesting that the "lithotome caché" was not original. This produced an answer where-in he challenged anyone to duplicate his results with the operation.

It is thought that he and his nephew, with whom he worked at his hospital, operated for vesicle calculus over 1000 times. In addition, he originated another instrument for suprapubic puncture of the bladder called the "sonde à dart."

At the time of his death in July 1781, he was considered a benefactor by his contemporaries and was lamented especially by the poor. Treating without charge, he was known to say, "Keep it; I must not injure your children."

After his death, operations for calculus disease were performed by surgeons who did various other surgical procedures and it was not for over 100 years that urinary surgery again emerged as a separate specialty in medicine. He was the last and the greatest of the itinerant lithotomists. *Can you name this doctor? Answer on page 173.*

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1. Corneley, D.A., and Ritter, J.A.: J.A.M.A. 160: 1219 (Apr. 7) 1956.
2. Mintz, A.A.: J. Ky. Acad. Gen. Pract. 6:26 (Jan.) 1959.





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PHYSICIAN FOR A 1700-BED PROGRESSIVE Neuropsychiatric Hospital—Salary \$9890 to \$12,770; extra allowance of 15% if Board Certified. Write: Manager, Veterans Administration Hospital, Danville, Illinois.

UNUSUALLY ATTRACTIVE OPPORTUNITY for well trained ophthalmologist who is board certified or board eligible. Up to \$25,000, the first year and possibility for partnership at the end of that period. Write Box 92R, Resident Physician, 1447 Northern Boulevard, Manhasset, New York.